

02340

DR. HINMELWRIGHT 2345 CERTIFICATE OF DEATH

Reg. Dist. No. **4**

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 508 36 MARYLAND AVENUE	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle P. Last BOWEN		4. DATE OF DEATH Month MARCH Day 22 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 21, 1867
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNABLE TO WORK - Odd jobs for Self		10b. KIND OF BUSINESS OR INDUSTRY Springfield, West Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DR. CHARLES J. BOWEN		14. MOTHER'S MAIDEN NAME MARY K. PARSONS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Hemorrhage 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma stomach DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 days (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/17 , 19 56 , to 3/22 , 19 56 , that I last saw the deceased alive on 3/21 , 19 56 , and that death occurred at 5:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md DATE SIGNED 3/22/56			
ACTUAL SIGNATURE George M. Simons		M.D. Cumberland, Md	
PHYSICIAN'S NAME (Type) George M. Simons, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-26-56	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		24a. REC'D BY REGISTRAR March 23, 1956	
24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

ALLIANCE

ON 12/10/55

12/10/55

30 WYATT AVENUE

10011111111111111111

25

25

25

WILLIAM

MALE

12/10/55

12/10/55

WHITE

WHITE

12/10/55

UNABLE TO WORK - 12/10/55

12/10/55

12/10/55

12/10/55

12/10/55

BUREAU V. S.

MAR 27 1956

RECEIVED

2407

CERTIFICATE OF DEATH

02341

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>				c. LENGTH OF STAY IN 1b <u>10 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>				d. STREET ADDRESS <u>207 Center St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Alvin</u> Middle <u>R.</u> Last <u>Bowser</u>				4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-25-1898</u>	
9. AGE (In years lost birthday) <u>57</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>	
11. BIRTHPLACE (State or foreign country) <u>Meyersdale, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John J. Bowser</u>		14. MOTHER'S MAIDEN NAME <u>Annie Bowman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-10-4016</u>		17. INFORMANT <u>Ward Bowser, 207 Center St. Frostburg</u>		Address <u>Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident</u> DUE TO <u>Hypertensive Cardiovascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>penal</u> DUE TO (c) <u>Dec.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>year or two</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 56</u> to <u>March 23, 1956</u> , that I last saw the deceased alive on <u>March 23, 1956</u> , and that death occurred at <u>6:58</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John B. Davis</u> M.D.				ADDRESS (Street, city or town, state) <u>2 Broadway, Frostburg, Md.</u>			
PHYSICIAN'S NAME (Type) <u>John B. Davis, M.D.</u>				DATE SIGNED <u>3/26/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3-26-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Salisbury</u>				(State) <u>Pa.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. B. Mattingly</u>				ADDRESS <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR <u>3-26-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. Harry N. Roe</u>				24c. DATE <u>3-26-56</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Out No.

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
SEX		RACE	
MARRIAGE		EDUCATION	
OCCUPATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
DATE OF BURIAL		PLACE OF BURIAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		PLACE	

BUREAU V. S.

APR 4 1956

RECEIVED

4 Feb

2346

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Bedford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyndman</u> <u>756-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>62 Sacred Heart Hospital</u>				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>Dale</u> Last <u>Bowser</u>				4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/8/56</u>		9. AGE (In years last birthday) yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Bowser</u>				14. MOTHER'S MAIDEN NAME <u>Iva Sides</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Chart</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.0 Atelectasis - pulmonary</u> DUE TO (b) <u></u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar. 11</u> , 19 <u>56</u> , to <u>Mar. 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar. 11</u> , 19 <u>56</u> , and that death occurred at <u>11:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>441 N. Center St. Cumberland, Md.</u> DATE SIGNED <u>3-12-56</u>							
ACTUAL SIGNATURE <u>William P. James</u> M.D.				PHYSICIAN'S NAME (Type) <u>William P. James M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>13 burial</u>		22b. DATE THEREOF <u>3-12-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hyndman Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hyndman Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Zeigler</u>				24a. REC'D BY REGISTRAR <u>March 12, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Frank, M.D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 13 1956

REVISED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2347

CERTIFICATE OF DEATH

02343

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		c. LENGTH OF STAY IN 1b 16 HRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near CUMBERLAND, rural	
f. STREET ADDRESS RT. #3 BEDFORD ROAD		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MILDRED LUCETTA BRADY		4. DATE OF DEATH Month Day Year MARCH 12 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 22, 1918
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper at		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY COLEMAN		14. MOTHER'S MAIDEN NAME GRACE BUTLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-20-7181	
17. INFORMANT Walter W. Brady Address Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure Cardiac Hypertrophy 421.4 DUE TO (b) Chronic Endocarditis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1951	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombocytopenic Purpura		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-9- , 19 51 , to 3-12-56 , that I last saw the deceased alive on 3-11- , 19 56 , and that death occurred at 8:35 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. J. Williams M.D.		ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 3-12-56	
PHYSICIAN'S NAME (Type) WILLIAM F. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/15/56	
22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR March 14, 1956 24b. REGISTRAR'S SIGNATURE W.R. Brady, M.D.	

CERTIFICATE OF DEATH

ALLEGANY

MARYLAND

DECEASED

ALLEGANY

DOUGLAS

18 1955

DOUGLAS

1713 E. BROAD ROAD

1713 E. BROAD ROAD

18 1955

18 1955

18 1955

18 1955

18 1955

18 1955

18 1955

MARYLAND

18 1955

18 1955

18 1955

BUREAU V. 2

18 16 1955

RECEIVED

Without corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02344

2348

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY X ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 16 HRS.					
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS Box 154 Ellerslie, Md.					
3. NAME OF DECEASED (Type or print) MRS. CLARA B. BREESE				4. DATE OF DEATH Month MARCH Day 9 Year 19 56					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 4, 1896			
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) W.VA. St. Leo			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME WILLIAM CAMP				14. MOTHER'S MAIDEN NAME Lavenia DELANEY					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Chronic Glomerulonephritis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Glomerulonephritis DUE TO (c) Chronic Glomerulonephritis								INTERVAL BETWEEN ONSET AND DEATH 8 days 18 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from 8 Mar 19 56 , to 9 Mar 19 56 , that I last saw the deceased alive on 9 Mar 19 56 , and that death occurred at 12:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 122 So Centre St, Cumberland, Md DATE SIGNED 10 Mar 56									
ACTUAL SIGNATURE James G. Stegmaier				PHYSICIAN'S NAME (Type) James G. Stegmaier					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/12/56		22c. NAME OF CEMETERY OR CREMATORY Prosperity Cem.			
22d. LOCATION (City, town, or county) (State) Prosperity, Penna.									
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR March 12, 1956			
24b. REGISTRAR'S SIGNATURE W.R. Frantz M.D.									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED WILLIAM CAMP		2. SEX MALE		3. RACE WHITE		4. AGE 65	
5. DATE OF DEATH MAY 1, 1956		6. TIME OF DEATH 10:00 AM		7. PLACE OF DEATH HOSPITAL		8. CITY BALTIMORE	
9. COUNTY BALTIMORE		10. STATE MARYLAND		11. ZIP CODE 21201		12. MANNER OF DEATH NATURAL	
13. CAUSE OF DEATH HEART DISEASE		14. ICD-9 CODE 410.9		15. PLACE OF BIRTH BALTIMORE, MD		16. DATE OF BIRTH MAY 1, 1891	
17. NAME OF PHYSICIAN DR. J. H. CAMP		18. NAME OF HOSPITAL HOSPITAL		19. NAME OF NURSE N. CAMP		20. NAME OF ATTENDING PHYSICIAN DR. J. H. CAMP	
21. NAME OF FUNERAL HOME F. CAMP		22. NAME OF BURIAL PLACE CAMP		23. NAME OF CEMETERY CAMP		24. NAME OF MINISTER CAMP	
25. NAME OF CORONER CAMP		26. NAME OF JURY CAMP		27. NAME OF JUDGE CAMP		28. NAME OF CLERK CAMP	
29. NAME OF WITNESS CAMP		30. NAME OF WITNESS CAMP		31. NAME OF WITNESS CAMP		32. NAME OF WITNESS CAMP	
33. NAME OF WITNESS CAMP		34. NAME OF WITNESS CAMP		35. NAME OF WITNESS CAMP		36. NAME OF WITNESS CAMP	
37. NAME OF WITNESS CAMP		38. NAME OF WITNESS CAMP		39. NAME OF WITNESS CAMP		40. NAME OF WITNESS CAMP	
41. NAME OF WITNESS CAMP		42. NAME OF WITNESS CAMP		43. NAME OF WITNESS CAMP		44. NAME OF WITNESS CAMP	
45. NAME OF WITNESS CAMP		46. NAME OF WITNESS CAMP		47. NAME OF WITNESS CAMP		48. NAME OF WITNESS CAMP	
49. NAME OF WITNESS CAMP		50. NAME OF WITNESS CAMP		51. NAME OF WITNESS CAMP		52. NAME OF WITNESS CAMP	
53. NAME OF WITNESS CAMP		54. NAME OF WITNESS CAMP		55. NAME OF WITNESS CAMP		56. NAME OF WITNESS CAMP	
57. NAME OF WITNESS CAMP		58. NAME OF WITNESS CAMP		59. NAME OF WITNESS CAMP		60. NAME OF WITNESS CAMP	
61. NAME OF WITNESS CAMP		62. NAME OF WITNESS CAMP		63. NAME OF WITNESS CAMP		64. NAME OF WITNESS CAMP	
65. NAME OF WITNESS CAMP		66. NAME OF WITNESS CAMP		67. NAME OF WITNESS CAMP		68. NAME OF WITNESS CAMP	
69. NAME OF WITNESS CAMP		70. NAME OF WITNESS CAMP		71. NAME OF WITNESS CAMP		72. NAME OF WITNESS CAMP	
73. NAME OF WITNESS CAMP		74. NAME OF WITNESS CAMP		75. NAME OF WITNESS CAMP		76. NAME OF WITNESS CAMP	
77. NAME OF WITNESS CAMP		78. NAME OF WITNESS CAMP		79. NAME OF WITNESS CAMP		80. NAME OF WITNESS CAMP	
81. NAME OF WITNESS CAMP		82. NAME OF WITNESS CAMP		83. NAME OF WITNESS CAMP		84. NAME OF WITNESS CAMP	
85. NAME OF WITNESS CAMP		86. NAME OF WITNESS CAMP		87. NAME OF WITNESS CAMP		88. NAME OF WITNESS CAMP	
89. NAME OF WITNESS CAMP		90. NAME OF WITNESS CAMP		91. NAME OF WITNESS CAMP		92. NAME OF WITNESS CAMP	
93. NAME OF WITNESS CAMP		94. NAME OF WITNESS CAMP		95. NAME OF WITNESS CAMP		96. NAME OF WITNESS CAMP	
97. NAME OF WITNESS CAMP		98. NAME OF WITNESS CAMP		99. NAME OF WITNESS CAMP		100. NAME OF WITNESS CAMP	

BUREAU V. S.

MAR 13 1956

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

02345

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg</u>		<u>5 wks.</u>		TOWN <u>Frostburg St.,</u>		<u>22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural give location) <u>Washington St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>EUGENE</u> <u>BRUNER</u>				<u>March 12, 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>white</u>	<u>widowed</u>	<u>11-18-1884</u>	<u>71</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>laborer-Dye House</u>		<u>Celanese Corp.</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>unknown</u>				<u>Sarah Donahue</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>220-10-2125A</u>		<u>Wm. Bruner, Pittsburgh, Pa.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
<u>434.2</u> IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>						<u>1 wks -</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Bronchial asthma</u>						<u>years -</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic heart disease</u>						<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 53</u>, to <u>3/12</u>, 19 <u>56</u>, that I last saw the deceased alive on <u>3/12</u>, 19 <u>56</u>, and that death occurred at <u>5:58</u> PM, from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>John B. Davis</u>		<u>7 Frostburg, Md.</u>		<u>3/14/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-15-56</u>		<u>St. Michaels Cemetery</u>		<u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>3-15-56</u>		<u>J. R. Durst</u>		<u>J. R. Durst</u>		<u>Frostburg, Md.</u>	

CERTIFICATE OF DEATH

Form 10-1-55

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE

10. SIGNATURE

11. SIGNATURE

12. SIGNATURE

13. SIGNATURE

14. SIGNATURE

15. SIGNATURE

16. SIGNATURE

17. SIGNATURE

18. SIGNATURE

19. SIGNATURE

20. SIGNATURE

BUREAU V. S.

MAR 20 1956

RECEIVED

Item 20 Film G195 4-6-58

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY GRANT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND				c. LENGTH OF STAY IN 1b 16 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BETTIE GOLDIZEN BURGESS				4. DATE OF DEATH Month Day Year MARCH 27 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-5-1889	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHRISTOPHER GOLDIZEN				14. MOTHER'S MAIDEN NAME ANNIE RIGGLEMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MEMORIAL HOSPITAL—MEMORIAL & WARWICK AVES.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 903.0 Pulmonary embolism, recurrent, massive IMMEDIATE CAUSE (a) Pulmonary embolism with infarction, rt. lung DUE TO (b) Contusion left chest wall, DUE TO (c) lying cause lost. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. INTERVAL BETWEEN ONSET AND DEATH 20 minutes 17 days 6 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell against bannister					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. Approx 6 wk before death		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Petersburg W. Va.	
21. I certify that I attended the deceased from 11 mn. 19 56 , to 27 mn. 19 56 , that I last saw the deceased alive on 26 mn. 19 56 , and that death occurred at 5:44 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. A. Van Ormer				ADDRESS (Street, city or town, state) Cumberland, Md.		DATE SIGNED 27 mn. 56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 29, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Carmel		22d. LOCATION (City, town, or county) (State) Petersburg W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Reyes Funeral Home				ADDRESS Reyes W. Va.		24a. REC'D BY REGISTRAR March 25, 1956	
				24b. REGISTRAR'S SIGNATURE W. L. Brant, M.D.			

MEDICAL CERTIFICATION

88

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED
ETHEL

AGE
72

SEX
F

DATE OF DEATH
APR 2 1956

TIME OF DEATH
11:00 AM

PLACE OF DEATH
HOSPITAL

11 CENTRAL AVENUE

HOSPITAL

ST

NY

NEW YORK

NEW YORK

ETHEL

1956

1956

WHITE

MALE

WEST VIRGINIA

NEW YORK

NEW YORK

WHITE RICHMOND

NEW YORK

NEW YORK

BUREAU V. 2

APR 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02347

DR. BALLIN

2350

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL - MEMORIAL AVE.				d. STREET ADDRESS 196 MAIN STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOHN Middle COBURN Last BYER				4. DATE OF DEATH Month MARCH Day 31 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 25, 1879	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY Pipe fitter		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HENRY BYER				14. MOTHER'S MAIDEN NAME AGNES LOVE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-4250		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Incarcerated inguinal hernia 1 week 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 1 day			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-1 , 19 54 , to 3-31 , 19 56 , that I last saw the deceased alive on 3-31 , 19 56 , and that death occurred at 10:25 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ralph W. Ballin				ADDRESS (Street, city or town, state) 62 Greene St. Cumberland, Md.			
PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.				DATE SIGNED 4-2-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 3, 1956		22c. NAME OF CEMETERY OR CREMATORY Lybarger Lutheran Cem.		22d. LOCATION (City, town, or county) (State) Madley Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR April 3, 1956	
				24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

— 1515 —

SIMILARITY TESTS

Y2175411

...

THE UNIVERSITY OF CHICAGO

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1001 1001 1001

51129

ALIBONNY 7234

02017357

BUREAU V. S.

APR 4 1956

RECEIVED

2351

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>Little Orleans</u>			
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Bernadine</u> Last <u>Callen</u>				4. DATE OF DEATH Month <u>3/</u> Day <u>4/</u> Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/13/76</u> <u>xx/xx/xx</u>		9. AGE (In years lost birthday) <u>80 yrs.</u>	10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland, Little Orleans</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Higgins</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Reel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Patient's Chart</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO <u>Arteriosclerosis</u> (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>March 1, 1956</u> to <u>March 5, 1956</u> that I last saw the deceased alive on <u>March 4, 1956</u> , and that death occurred at <u>10:35 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cumberland, Md</u> DATE SIGNED <u>3-5-56</u> ACTUAL SIGNATURE <u>J. T. Johnson</u> M.D. <u>Cumberland, Md</u> PHYSICIAN'S NAME (Type) <u>J. T. JOHNSON, JR., M.D.</u> <u>CUMBERLAND, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/7/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HAFER, John J. Hafer</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>March 8, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. R. Feantz, M.D.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 6 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS MC HENRY 11X-2 ✓			
3. NAME OF DECEASED (Type or print) First FRANK Middle CALLIS Last CALLIS				4. DATE OF DEATH Month MARCH Day 21 Year 19 56			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 10, 1868 87 yrs.	
9. AGE (In years last birthday) 87		IF UNDER 1 YEAR Months 8 Days 21 Hours 11 Min. 56		IF UNDER 24 HRS. Months 8 Days 21 Hours 11 Min. 56			
10a. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer & Carpenter for Self				10b. KIND OF BUSINESS OR INDUSTRY WEST VIRGINIA			
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME EDWARD CALLIS				14. MOTHER'S MAIDEN NAME HANNAH BULLOUGH Anna Bullough			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL-WARWICK AND MEMORIAL AVE.			
17. INFORMANT MEMORIAL HOSPITAL-WARWICK AND MEMORIAL AVE.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis with 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uremia DUE TO (c) P INTERVAL BETWEEN ONSET AND DEATH P							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3-15-56 , 19 56 , to 3-21-56 , 19 56 , that I last saw the deceased alive on 3-21-56 , 19 56 , and that death occurred at 4:02 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED Howard L. Tolson, M.D.							
ACTUAL SIGNATURE Howard L. Tolson				PHYSICIAN'S NAME (Type) Howard L. Tolson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF March 24, 1956			
22c. NAME OF CEMETERY OR CREMATORY Hoyes Cemetery				22d. LOCATION (City, town, or county) (State) Hoyes, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Donald Newman				24a. REC'D BY REGISTRAR March 23, 1956			
ADDRESS Grantville Md				24b. REGISTRAR'S SIGNATURE Walter R. Mantz, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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AMERICAN TOWNS

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BUREAU V. S.

MAR 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2353 CERTIFICATE OF DEATH

Reg. Dist.

02350

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W VA. b. COUNTY Hampshire	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BURLINGTON W VA. 85x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 MEMORIAL HOSPITAL		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle W Last CARSKADON		4. DATE OF DEATH Month MARCH Day 30 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1865 DEC. 12, 1865
9. AGE (In years last birthday) 90		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Headsville, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ISAAC CARSKADON		14. MOTHER'S MAIDEN NAME SUSAN SHEETZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Memorial Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Far advanced generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3. 28 , 19 56 to 3. 31 , 19 56 ; that I last saw the deceased alive on 3. 31 , 19 56 , and that death occurred at 1:21 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. F. Williams M.D.		ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 3-31-56	
PHYSICIAN'S NAME (Type) W. F. Williams, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 3, 1956	22c. NAME OF CEMETERY OR CREMATORY Headsville Church Cem.	22d. LOCATION (City, town, or county) (State) Headsville, West Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Markwood Funeral Home, Keyser, West Virginia		24a. REC'D BY REGISTRAR April 2, 1956 24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• MAY 1973/1974

JANUARY 1984

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La. Acad. Sci. 55:109-110

BUREAU V. B.

APR 4 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02351

2354

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Allegany</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Barton</u> STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Martha</u> (First) <u>Chappell</u> (Middle) (Last)				4. DATE OF DEATH <u>Mar.</u> <u>23</u> 19 <u>56</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>Aug. 6 - 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Barton Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James O. Neal</u>				14. MOTHER'S MAIDEN NAME <u>Martha Biggs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Wm. Chappell 431 Cumberland ST. Cumberland MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.2</u>				18. MEDICAL CERTIFICATION <u>Cerebral Hemorrhage.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
IMMEDIATE CAUSE (A)				<u>Cerebral arteriosclerosis</u>		<u>?</u>	
ANTECEDENT CAUSE(S) DUE TO				<u>Chronic Myocarditis</u>		<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>Senile psychosis.</u>		<u>6 mos.</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 2, 1956</u> , to <u>Mar. 23, 1956</u> , that I last saw the deceased alive on <u>Mar. 23, 1956</u> , and that death occurred at <u>9:00</u> M., from the causes and on the date stated above.							
SIGNATURE <u>James E. McLean</u> M.D.				ADDRESS (Street, city, town, state) <u>49 Green St. Maryland, Ind</u>		DATE SIGNED <u>3-23-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-26-56</u>		NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cem.</u>		LOCATION (City, town, or county) (State) <u>Marion, Ind</u>	
24. REC'D BY REGISTRAR <u>March 26, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter R. Hantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. Baal, Hutterport, Md</u>		ADDRESS	

CERTIFICATE OF DEATH

FILE NO. 100

LOCAL RESIDENCE (NUMBER OF RECORD)

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

REASON FOR ENTRY

DATE OF DEPARTURE

REASON FOR DEPARTURE

DATE OF RETURN

REASON FOR RETURN

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

REASON FOR ENTRY

DATE OF DEPARTURE

REASON FOR DEPARTURE

BUREAU V. 1

MAR 28 1956

RECEIVED

2419

CERTIFICATE OF DEATH

Reg. Dist. No.

8

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lonadoning		c. LENGTH OF STAY IN 1b 79 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 100		d. STREET ADDRESS X	
3. NAME OF DECEASED (Type or print) First Nancy Middle Clupp Last Clupp		4. DATE OF DEATH Month March Day 5 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1876
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Coleman		14. MOTHER'S MAIDEN NAME Margaret Matthews Murphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Pauline Matthews Lonaconing, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X Congestive heart failure DUE TO (b) Essential hypertension DUE TO (c) Chronic asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 21, 1956 , to Mar 5, 1956 , that I last saw the deceased alive on Mar 5, 1956 , and that death occurred at 10:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leslie R. Miles Jr.		ADDRESS (Street, city or town, state) Lonaconing, MD.	
DATE SIGNED			
PHYSICIAN'S NAME (Type) Leslie R. Miles JR.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF MAR 7, 1956	
22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		22d. LOCATION (City, town, or county) (State) Westernport, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
24a. REC'D BY REGISTRAR 3-7-56		24b. REGISTRAR'S SIGNATURE Jannette M. Pool	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

MAR 14 1956

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2355 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home 114 Seymour Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>M</u> Last <u>Codire</u>				4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13, 1882</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min. <u>73</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>Peter Codire</u>		14. MOTHER'S MAIDEN NAME <u>Mary Clancy</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>705-05-5290</u>		17. INFORMANT <u>Mrs. Regina Codire, 114 Seymour St., City.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 year</u> <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-8-</u> , 19 <u>54</u> , to <u>3-11-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-11-</u> , 19 <u>56</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. Brings</u>				ADDRESS (Street, city or town, state) <u>576 W. 11th St. Cumberland, Md.</u>			
PHYSICIAN'S NAME (Type) <u>L. Brings, M.D.</u>				DATE SIGNED <u>March 13, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 14, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>March 13, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>W. R. Frantz, M.D.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956 1.4

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2356 Item #3, Film G195 4/9/56 mb

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>17 hrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Corrigansville</u>			
3. NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>Wellington</u> Last <u>Conner</u>				4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>19 56</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 5-1904</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Textile worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Conner</u>				14. MOTHER'S MAIDEN NAME <u>Martha Groom</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes <u>W.W.I</u>				16. SOCIAL SECURITY NO. <u>217-10-6355</u>			
17. INFORMANT <u>Memorial Hospital, Cumberland, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Myocardial infarction</u> (c) <u>Pulmonary edema & congestion.</u> INTERVAL BETWEEN ONSET AND DEATH <u>17 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>				DATE SIGNED			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 20-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 23, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Porter Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>near Hyndman, Pennsylvania.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Zeigler, Hyndman, Pennsylvania.</u>				24a. REC'D BY REGISTRAR <u>March 21, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W.L. Krantz, M.D.</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL		DATE OF BURIAL	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF SECOND WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF THIRD WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF FOURTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF FIFTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF SIXTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF SEVENTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF EIGHTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF NINTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF TENTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF ELEVENTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF TWELFTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF THIRTEENTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF FOURTEENTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF FIFTEENTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF SIXTEENTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF SEVENTEENTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF EIGHTEENTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF NINETEENTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF TWENTIETH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF TWENTY-FIRST WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF TWENTY-SECOND WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF TWENTY-THIRD WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF TWENTY-FOURTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF TWENTY-FIFTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF TWENTY-SIXTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF TWENTY-SEVENTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF TWENTY-EIGHTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF TWENTY-NINTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF THIRTIETH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF THIRTY-FIRST WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF THIRTY-SECOND WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF THIRTY-THIRD WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF THIRTY-FOURTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF THIRTY-FIFTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF THIRTY-SIXTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF THIRTY-SEVENTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF THIRTY-EIGHTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF THIRTY-NINTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF FORTIETH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF FORTY-FIRST WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF FORTY-SECOND WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF FORTY-THIRD WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF FORTY-FOURTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF FORTY-FIFTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF FORTY-SIXTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF FORTY-SEVENTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF FORTY-EIGHTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF FORTY-NINTH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	
SIGNATURE OF FIFTIETH WITNESS		DATE		TIME		PLACE		COUNTY		STATE	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2409 CERTIFICATE OF DEATH

02355

Reg. Dist. No. 6

Items 9, 14 FilmG194 3-19-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harry & Allegany</u> MARYLAND		STATE <u>MD</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u> 43		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u> 43	
CITY OR TOWN <u>Westernport</u>		LENGTH OF STAY (in this place) <u>60 yrs</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>422 Spruce St</u>		STREET ADDRESS (If rural give location) <u>422 Spruce St</u>	
3. NAME OF DECEASED (First) <u>HARRY</u> (Middle) <u>OSBORNE</u> (Last) <u>COOK</u>				4. DATE OF DEATH (Month) <u>MARCH</u> (Day) <u>10</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>August 7, 1899</u>	9. AGE last birthday <u>56</u> yrs.	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
10a. USUAL OCCUPATION (Give kind of work done during "most of working life, even if retired") <u>Laborer-Rex. Chinese Corp</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chinese Corp</u>		11. BIRTHPLACE (State or foreign country) <u>BARTON, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Cook</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Spencer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no; or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-01-9024 A</u>		17. INFORMANT & ADDRESS <u>403 Maryland Ave Westernport, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>442X Chronic Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 Years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Nephritis</u>				<u>5 Years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arterio-Sclerosis</u>				<u>5 Years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Lobar Pneumonia</u>				<u>1 Day</u>			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		21b. PLACE (Home, farm, factory, of injury, street, office bldg., etc.) <u>None</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 10, 1951</u> to <u>Mar 10, 1956</u> , that I last saw the deceased alive on <u>Mar 10, 1956</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul A. Wilson</u> M.D.		ADDRESS (Street, city, town, state) <u>Piedmont W. Va.</u>		DATE SIGNED <u>12 Mar. 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>13 MARCH 56</u>		NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		LOCATION (City, town, or county) <u>Westernport Md</u>	
24. REC'D BY REGISTRAR <u>3-13-56</u>		REGISTRAR'S SIGNATURE <u>Mr. John C. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Brual</u>		ADDRESS <u>Westernport</u>	

CERTIFICATE OF DEATH

Reg. No. 10

1. NAME AND PLACE OF BIRTH OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. PLACE OF INTERMENT

8. NAME OF MINISTER

9. NAME OF WITNESSES

10. NAME OF REGISTRAR

11. NAME OF DECEASED

12. NAME OF DECEASED

13. NAME OF DECEASED

14. NAME OF DECEASED

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48. NAME OF DECEASED

49. NAME OF DECEASED

50. NAME OF DECEASED

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MAR 14 1955

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SECTION ONE

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT IT IS SIGNED BY THE MINISTER OF THE GOSPEL OR BY A MINISTER OF THE GOSPEL WHO IS A MEMBER OF THE CLERGY OF THE STATE OF MARYLAND. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2357 CERTIFICATE OF DEATH

02356

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>				c. LENGTH OF STAY IN 1b <u>8 days, 12 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>62 Sacred Heart Hospital</u>				d. STREET ADDRESS <u>Valley Road, Route #3.</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Watson</u> Last <u>Cooper</u>				4. DATE OF DEATH Month <u>3</u> Day <u>13</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-16-69</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>13</u> Hours <u>19</u> Min.	IF UNDER 24 HRS. Months <u>3</u> Days <u>13</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland City</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania Bedford</u>	
13. FATHER'S NAME <u>Jonathan Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Sarah College Cooper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-10-7806</u>		17. INFORMANT <u>Patient's chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____		(County) _____ (State) _____	
21. I certify that I attended the deceased from <u>3/4</u> , 19 <u>56</u> , to <u>3/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/12</u> , 19 <u>56</u> , and that death occurred at <u>8:15</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. W. Trevaskis, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Cumberland, Md.</u> DATE SIGNED <u>3/13/56</u>			
PHYSICIAN'S NAME (Type) <u>R.W.Trevaskis, Sr. M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chaneyville Meth. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bedford County, Penn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H afe John J. Hafer</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>March 13, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W.R. Frank, M.D.</u>			

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2358 CERTIFICATE OF DEATH

Reg. Dist. No.

02357
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1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 734 Maryland Ave.			
3. NAME OF DECEASED (Type or print) First Mary Middle Ellen Last Crawford				4. DATE OF DEATH Month March Day 6 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/10/86	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Samuel McNabb				14. MOTHER'S MAIDEN NAME Margaret Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				16. SOCIAL SECURITY NO. None		17. INFORMANT Patient's Chart	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis & decompensation 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) Secondary Anemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 yrs. 10 yrs. 6 mos.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Mar. 5 , 19 56 , to Mar. 6 , 19 56 , that I last saw the deceased alive on Mar. 6 , 19 56 , and that death occurred at 6:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Clay E. Durrett M.D.				ADDRESS (Street, city or town, state) Cumberland, Md.			
DATE SIGNED 3/7/56							
PHYSICIAN'S NAME (Type) CLAY E. DURRETT CUMBERLAND, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 9, 1956		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HAFERS John J. Hafer,				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR March 8, 1956	
24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		JAN 5 1921		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH	
1000 E. 10th St., Memphis, Tenn.		Attorney		High School		Married		Methodist		Heart Disease	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
APR 4 1968		Memphis, Tenn.		Natural		[Signature]		[Signature]		[Signature]	
DATE OF BURIAL		PLACE OF BURIAL		MANNER OF BURIAL		CERTIFICATE OF BURIAL		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
APR 10 1968		Greenwood Cemetery, Memphis, Tenn.		Burial		[Signature]		[Signature]		[Signature]	

BUREAU V. 8

MAR 12 1956

RECEIVED

CERTIFICATE OF DEATH

2359

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02 TOWN Cumberland</u>		LENGTH OF STAY (in this place) <u>1yr. 6mo. 21da.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>near Cumberland, rural</u>		TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1/X Sylvan Retreat</u>				STREET ADDRESS (If rural give location) <u>R.F.D. #3, Bedford Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Catherine</u> (Middle) <u>Matilda</u> (Last) <u>Critzman</u>				(Month) <u>Mar.</u> (Day) <u>21</u> (Year) <u>19 56</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>3/4/1875</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Hughs</u>				14. MOTHER'S MAIDEN NAME <u>Margaret (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Melvin Critzman Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>334X Pulmonary Hypostasis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cerebral arteriosclerosis</u>				?			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile psychosis</u>				3 yrs.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 4, 19 54</u> , to <u>Mar. 24, 19 56</u> , that I last saw the deceased alive on <u>Mar. 24, 19 56</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Samuel B. McLean</u>				M. D. <u>49 Greene St.</u>		DATE SIGNED <u>3-29-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/27/56</u>		NAME OF CEMETERY OR CREMATORY <u>Zion Memorial Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>March 27, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter R. Hantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc. Cumberland, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1935

HEALTH AND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

CERTIFICATE OF DEATH

Age at Death

1. Name of Deceased

2. Date of Death

3. Sex

4. Race

5. Place of Birth

6. Date of Birth

7. Cause of Death

8. Duration of Illness

9. Place of Death

10. Signature of Physician

11. Signature of Registrar

12. Signature of Coroner

13. Signature of Medical Examiner

14. Signature of Burial Officer

15. Signature of Undertaker

16. Signature of Funeral Home

17. Signature of Cemetery

18. Signature of Burial Society

19. Signature of Religious Society

20. Signature of Other

21. Signature of Other

22. Signature of Other

23. Signature of Other

24. Signature of Other

25. Signature of Other

26. Signature of Other

27. Signature of Other

28. Signature of Other

29. Signature of Other

30. Signature of Other

31. Signature of Other

32. Signature of Other

33. Signature of Other

34. Signature of Other

35. Signature of Other

36. Signature of Other

37. Signature of Other

38. Signature of Other

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50. Signature of Other

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60. Signature of Other

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62. Signature of Other

63. Signature of Other

64. Signature of Other

RECEIVED
1935
BUREAU V. S.
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02359

2410

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
CITY OR TOWN <u>Frostburg</u>		LENGTH OF STAY (in this place) <u>8 days</u>		STREET ADDRESS <u>135 S. Water St.</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>							
3. NAME OF DECEASED (Type or Print) <u>EDITH</u> (First) <u>(CRUMP)</u> (Middle) <u>CROWE</u> (Last)				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>15</u> (Year) <u>1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>2-28-1887</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Crump</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Roeder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u> </u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Frederick Crowe, Frostburg, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <u>myocardial failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive heart disease</u>				<u>4 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Metastatic Carcinoma Spin (3+4 DV) from Breast</u>							
19a. DATE OF OPERATION <u>6/26/55</u>				19b. MAJOR FINDINGS OF OPERATION <u>Adenocarcinoma left breast</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>November 1954</u> , to <u>March 15, 1956</u> , that I last saw the deceased alive on <u>March 14, 1956</u> , and that death occurred at <u>1:40 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Arthur J. Purdy, M.D.</u>				DATE SIGNED <u>March 15, 1956</u>			
ADDRESS (Street, city, town, state) <u>48 Broadway, Frostburg, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-17-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR <u>Mr. Nancy N. Roe</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	
DATE <u>3-17-56</u>							

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

CERTIFICATE OF DEATH

Reg. Dist. No.

LOCAL HEALTH OFFICE OF RECORD

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

PREVIOUS ILLNESS

DATE OF PREVIOUS ILLNESS

DATE OF PREVIOUS ILLNESS

DATE OF PREVIOUS ILLNESS

DATE OF PREVIOUS ILLNESS

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BUREAU V. 3

MAR 20 1956

RECEIVED

1. Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

02360

Reg. Dist. No. 4

2360

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>ALLEGANY</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>ALLEGANY</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CUMBERLAND</u>	LENGTH OF STAY (in this place) <u>36 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CUMBERLAND</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>40 HUMBIRD ST</u>		STREET ADDRESS (If rural give location) <u>40 HUMBIRD STREET</u>	

3. NAME OF DECEASED (Type or Print)	(First) <u>BERTHA</u> (Middle) <u>LUCINDA</u> (Last) <u>DARNLEY</u>	4. DATE OF DEATH (Month) (Day) (Year)
		<u>MARCH 20 1956</u>

5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>APRIL 14, 1885</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
					Months	Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u>	11. BIRTHPLACE (State or foreign country) <u>MANNS CHOICE, PA</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13. FATHER'S NAME <u>ADAM DIEHL</u>	14. MOTHER'S MAIDEN NAME <u>HANNAH COMP</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>NO</u> (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT & ADDRESS <u>MISS EDITH DARNLEY, CUMBERLAND, AND MD</u>
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I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
491X IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>	ANTECEDENT CAUSE(S) DUE TO (B) <u>Acute Bronchitis</u>		<u>4 days</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Cerebral Hemorrhage</u>			<u>7 days</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>Road-parkin</u>	<u>5 hrs</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from March 20, 1956 to March 24, 1956, that I last saw the deceased alive on March 20, 1956, and that death occurred at 9 P M, from the causes and on the date stated above.

SIGNATURE <u>Alan S. Murray</u>	ADDRESS (Street, city, town, state) <u>Cumberland and March 22, 1956</u>	DATE SIGNED <u>March 22, 1956</u>
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23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>MAR 24, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>UNION CEMETERY</u>	LOCATION (City, town, or county) (State) <u>MEYERSDALE PA</u>
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24. REC'D BY REGISTRAR <u>March 23, 1956</u>	REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Ziegler, Hyndman, Pa.</u>
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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

1. DECEASED'S NAME (Last, first, middle)

DATE

PLACE

SEX

AGE

CAUSE

MANNER

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

US BIRTH

ALIEN

IMMIGRATION

STATUS

RESIDENCE

DATE

PLACE

SEX

AGE

CAUSE

MANNER

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

US BIRTH

ALIEN

IMMIGRATION

STATUS

RESIDENCE

BUREAU V. S.

MAR 27 1956

RECEIVED

Handwritten signature and initials

DR. JAMES

2361

CERTIFICATE OF DEATH

Reg. Dist. No.

02361

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY Bedford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEDFORD, rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS R.F.D. #3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle M. Last DIEHL				4. DATE OF DEATH Month MARCH Day 4 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 5, 1898	
9. AGE (In years last birthday) 57		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE & Nurse				10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME DOUGLAS SOMMERVILLE				14. MOTHER'S MAIDEN NAME MARGARET WALKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 235-34-5744		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia DUE TO (c) Pneumonia INTERVAL BETWEEN ONSET AND DEATH 2 days 2 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Mar. 3, 1956 , to Mar. 4, 1956 , that I last saw the deceased alive on Mar. 4, 1956 , and that death occurred at 6:05 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 441 N. Centre St. Cumberland, Md. DATE SIGNED Mar. 7, 1956							
ACTUAL SIGNATURE William P. James				PHYSICIAN'S NAME (Type) WILLIAM P. JAMES			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Mar. 7, 1956		22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery	
22d. LOCATION (City, town, or county) Cumberland, Md.				22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE W. H. H. H.				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR March 7, 1956	
24b. REGISTRAR'S SIGNATURE W. R. Hantz, M.D.				24c. DATE March 7, 1956			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

W. J. JAMES

ADMINISTRATIVE

ADMINISTRATIVE

1 DAY

2ND DAY

CRIMINAL RECORD

1890-1900

MARCH

DEATH

W. J. JAMES

MARCH 2, 1900

WHITE

2ND DAY

MARYLAND

NO OTHERS

MARGARET WALKER

DEATHS OF THE

CRIMINAL RECORD - BUREAU OF HEALTH

2nd day

2nd day

BUREAU V. 1

Mar. 3 1900

Mar. 4 1900

in case of James

W. J. JAMES

RECEIVED

Mar 6 1900

HIMMELWRIGHT

2362

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.				c. LENGTH OF STAY IN 1b 7 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 950 MARYLAND AVENUE			
3. NAME OF DECEASED (Type or print) First CHARLES Middle T Last DIFFENDALL				4. DATE OF DEATH Month 3- Day 28 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 16, 1889	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) PENNA. Chambersburg	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN F. DIFFENDALL				14. MOTHER'S MAIDEN NAME ELLEN M. LOUDENSLAGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 705-05-4515		17. INFORMANT Address MEMORIAL HOSPITAL MEMORIAL AVENUE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181X Carcinoma of Bladder metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH approx 1 yr.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from Nov , 19 54 , to March , 19 56 , that I last saw the deceased alive on March 27 , 19 56 , and that death occurred at 6:25 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 133 Virginia Ave DATE SIGNED 3/29/56							
ACTUAL SIGNATURE G. Overton Himmelwright M.D.				PHYSICIAN'S NAME (Type) G. Overton Himmelwright, M.D. Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-31-56		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Searpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR March 31, 1956	
				24b. REGISTRAR'S SIGNATURE W. L. Frank, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MINIMUM

2001

03303

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED JOHN A. DEERWALL		DATE OF BIRTH APRIL 12, 1908		AGE 43 YEARS	
SEX MALE		RACE WHITE		EDUCATION HIGH SCHOOL	
MARRIAGE MARRIED		DATE OF MARRIAGE APRIL 12, 1938		PLACE OF MARRIAGE BALTIMORE, MD	
OCCUPATION FIREWORKS		PLACE OF BIRTH BALTIMORE, MD		DATE OF DEATH APRIL 12, 1956	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		PLACE OF DEATH BALTIMORE, MD	
SIGNATURE OF PHYSICIAN J. A. DEERWALL		SIGNATURE OF WITNESSES J. A. DEERWALL		SIGNATURE OF REGISTRAR J. A. DEERWALL	
DATE OF SIGNATURE APRIL 12, 1956		DATE OF SIGNATURE APRIL 12, 1956		DATE OF SIGNATURE APRIL 12, 1956	
PLACE OF SIGNATURE BALTIMORE, MD		PLACE OF SIGNATURE BALTIMORE, MD		PLACE OF SIGNATURE BALTIMORE, MD	

BUREAU V. R.

APR 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2420 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

- 02363

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>		c. LENGTH OF STAY IN 1b <u>36 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beechwood St.</u>				d. STREET ADDRESS <u>Beechwood St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jessie</u> <u>Dinning</u>				4. DATE OF DEATH Month Day Year <u>March</u> <u>30</u> <u>19 56</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 4-1878</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Airshire-Scorland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Dinning</u>				14. MOTHER'S MAIDEN NAME <u>Jane Houston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Rebecca Dinning, Lonaconing, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular-renal disease.</u> About <u>3 years</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. H. Deming M.D.</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 30-1956</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/2/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>George Eichhorn, Lonaconing, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>4/2/56</u>		24b. REGISTRAR'S SIGNATURE <u>Janette M. Boal</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 5 1954

RECEIVED

W.F.WMS.

2363

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,				c. LENGTH OF STAY IN 1b 16 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY 85x-3-1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 24 Knobley Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JANE Middle ELIZABETH Last DREYER				4. DATE OF DEATH Month 3 Day 22 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-13-1901	
				9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Making accessories at Kelly Tire Plant &				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME ALEXANDER KALSO KALSO				13. MOTHER'S MAIDEN NAME MARY MEAGER MEAGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-07-0967		17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphatic Leukemia 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Since July '55	
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 7:22:11, 1956 , to 3:22:11, 1956 , that I last saw the deceased alive on 3:21, 1956 , and that death occurred at 6:35A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W.F. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland		DATE SIGNED 3/22/56	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 24, 1956		22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Maryland.				24a. REC'D BY REGISTRAR March 23, 1956		24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED		DATE OF DEATH		PLACE OF DEATH	
ALEXANDER WILSON		1956		HOSPITAL	
SEX		AGE		RACE	
MALE		41		WHITE	
BIRTH DATE		BIRTH PLACE		CITY	
1915		WEST VIRGINIA		MARTINSBURG	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
LABORER		HEART DISEASE		NATURAL	
EDUCATION		SIGNATURE OF DECEASED		SIGNATURE OF PHYSICIAN	
HIGH SCHOOL					
MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE	
YES		1940		HOSPITAL	
SPOUSE		DATE OF DEATH		PLACE OF DEATH	
JANE WILSON		1956		HOSPITAL	
RELATIONSHIP		DATE OF DEATH		PLACE OF DEATH	
WIFE		1956		HOSPITAL	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
1956		HOSPITAL		NATURAL	
SIGNATURE OF DECEASED		SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
1956		HOSPITAL		NATURAL	

BUREAU V. S.

MAR 27 1956

RECEIVED

2364

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 60 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 414 Grand Ave.				d. STREET ADDRESS 414 Grand Ave.			
3. NAME OF DECEASED (Type or print) First Charles Middle Thomas Last Dulin				4. DATE OF DEATH Month 3 Day 3 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 16, 1876	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Keyser, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gabriel M. Dulin				14. MOTHER'S MAIDEN NAME Sarah H. Soule			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. C. E. Bratt, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO uraemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocarditis in compensation DUE TO 5 yrs (c) _____						INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from Feb. 15, 1956 to Mar. 3, 1956 , that I last saw the deceased alive on Feb. 15, 1956 , and that death occurred at 1 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Clay E. Jurett		ADDRESS (Street, city or town, state) Cumberland		DATE SIGNED 3/5/56			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-6-56	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR March 6, 1956		24b. REGISTRAR'S SIGNATURE W. R. Grant, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	

2365

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MR. HERBERT EARSON				4. DATE OF DEATH Month MARCH Day 8 Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 20, 1890	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager of News Center				10b. KIND OF BUSINESS OR INDUSTRY News Company		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JAMES EARSON			
14. MOTHER'S MAIDEN NAME LUCINDA WISE				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 214-05-5740				17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage with right hemiplegia DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) none DUE TO (c) none							INTERVAL BETWEEN ONSET AND DEATH 8 da. 20 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. none p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
20f. (City or town) none				20g. (County) none		20h. (State) none	
21. I certify that I attended the deceased from March 1, 1956 to March 8, 1956 , that I last saw the deceased alive on March 8, 1956 , and that death occurred at 10:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. L. Hallinan M.D.				ADDRESS (Street, city or town, state) 140 Bedford St. Cumberland, Maryland			
PHYSICIAN'S NAME (Type) J.P. Hallinan M. D.				DATE SIGNED 3/9/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 12, 1956		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumberland MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				ADDRESS 117 Frederick St. P.O. Box 12, 1956			
24a. REC'D BY REGISTRAR W.R. Priddy, M.D.				24b. REGISTRAR'S SIGNATURE W.R. Priddy, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02367

Reg. Dist. No. 4

2366

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>30yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 F- Frazier Village.</u>				d. STREET ADDRESS <u>14-F- Frazier Village</u>			
3. NAME OF DECEASED (Type or print) <u>Rose Coddington Ennis</u>				4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1882</u>		9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ownhome</u>		11. BIRTHPLACE (State or foreign country) <u>Oakland, Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Coddington</u>				14. MOTHER'S MAIDEN NAME <u>Cecelia Jamison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Carl V. Ennis</u> Address <u>Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease - Chronic</u> DUE TO (c) <u>Myocarditis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>March</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 18</u> , 19 <u>56</u> , and that death occurred at <u>11:00 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>133 Virginia Ave, Cumberland, Md</u> DATE SIGNED <u>3/18/56</u>							
ACTUAL SIGNATURE <u>[Signature]</u>				PHYSICIAN'S NAME (Type) <u>G. Overton Himmelfwright, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-20-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Oakland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>March 19, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>W.R. Harty, M.D.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES H. HARRIS		Male		45		1910		Maryland		Farmer		Married		White	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF WITNESSES		16. SIGNATURE OF DECEASED	
April 15, 1956		10:30 AM		Home		Heart Disease		Natural		J. H. Harris		J. H. Harris		J. H. Harris	
17. COUNTY		18. CITY		19. STATE		20. ZIP CODE		21. REGISTRAR'S NAME		22. REGISTRAR'S ADDRESS		23. REGISTRAR'S PHONE		24. REGISTRAR'S SIGNATURE	
Baltimore		Baltimore		Maryland		21201		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

BUREAU V. S.

MAR 20 1956

RECEIVED

2367

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY <u>Allegheny</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>605 Woodlawn Terrace</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Tabitha</u> Middle <u>J.</u> Last <u>Fisher</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/9/09</u>	
9. AGE (In years lost birthday) <u>46 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Frank Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Maryland Walker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-18-1470</u>		17. INFORMANT <u>Virginia F. Lasher</u> Address <u>Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral embolism</u> DUE TO <u>416X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO <u>rheumatic heart</u> (c) <u>Myocardial infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 week</u> <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>2-28</u> , 19 <u>56</u> , to <u>3-3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-2</u> , 19 <u>56</u> , and that death occurred at <u>3:11</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. Brings</u>				ADDRESS (Street, city or town, state) <u>57 Green St., Cumberland, Md.</u>			
PHYSICIAN'S NAME (Type) <u>L. Brings</u>				DATE SIGNED <u>3-3-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox</u> ADDRESS <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>March 5, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>M. D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0538

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1-10-55

CERTIFICATE OF DEATH

NAME OF DECEASED <i>Charles E. Smith</i>		DATE OF DEATH <i>10-25-55</i>	
AGE <i>45</i>		SEX <i>M</i>	
RACE <i>W</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Engineer</i>		MARRIAGE <i>Married</i>	
PLACE OF BIRTH <i>St. Louis, Mo.</i>		PLACE OF DEATH <i>Baltimore, Md.</i>	
CAUSE OF DEATH <i>Myocardial Infarction</i>		MANNER OF DEATH <i>Natural</i>	
DATE OF REPORT <i>10-26-55</i>		REPORTED BY <i>Dr. J. H. Smith</i>	
SIGNATURE OF REPORTER <i>J. H. Smith</i>		SIGNATURE OF DECEASED <i>Charles E. Smith</i>	
DATE OF SIGNATURE <i>10-26-55</i>		DATE OF SIGNATURE <i>10-25-55</i>	
PLACE OF SIGNATURE <i>Baltimore, Md.</i>		PLACE OF SIGNATURE <i>Baltimore, Md.</i>	
OFFICIAL USE		OFFICIAL USE	

BUREAU V. 8

1956

RECEIVED

DR. R. J. WILLIAMS 2368 CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND				c. LENGTH OF STAY IN 1b 35 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) 60 MEMORIAL HOSPITAL				d. STREET ADDRESS 310 PARK STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First TRESA Middle M. Last FRANTZ				4. DATE OF DEATH Month MARCH Day 2 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 9, 1894	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLEANING				10b. KIND OF BUSINESS OR INDUSTRY BOARD OF EDUCATION			
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOSEPH HEDRICK				14. MOTHER'S MAIDEN NAME Eliza A. H. REXROAD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO. 216-22-5555		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis (abdominal) DUE TO Ovarian Malignancy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ovarian Malignancy DUE TO Ovarian Malignancy (c) Ovarian Malignancy				INTERVAL BETWEEN ONSET AND DEATH 6 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cumberland				20g. (County) Cumberland		20h. (State) Maryland	
21. I certify that I attended the deceased from 12/15/55 19____, to 3/2/56 19____, that I last saw the deceased alive on 3/2/56 19____, and that death occurred at 4:20 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. J. Williams				ADDRESS (Street, city or town, state) Cumberland			
PHYSICIAN'S NAME (Type) R. J. Williams				DATE SIGNED 3/3/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/56		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR March 4, 1956	
				24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

W. H. MILLER

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BUREAU V. S.

MAR 7 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2369

02370
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		c. LENGTH OF STAY IN 1b <u>7 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(rural) Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>60 Memorial Hospital</u>			d. STREET ADDRESS <u>R.F.D. #3 Valley Rd. /</u> <u>Bowmans Addition</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Gary</u> Middle <u>Lynn</u> Last <u>Gentry</u>			4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>19 56</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 28-1950</u>		9. AGE (In years last birthday) <u>5</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>James H. Gentry</u>			14. MOTHER'S MAIDEN NAME <u>Mary M. Weimer</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Memorial Hospital records.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock also 1st, 2nd, & 3rd degree burns</u> DUE TO (b) <u>of entire body, except feet.</u> DUE TO (c) <u>Throw gasoline on fire in yard, clothes caught fire.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>in yard. Boys built a fire</u> <u>gasoline in can was thrown on fire, flare caught clothes</u>					INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs.</u>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Boys built a fire</u>			
20c. TIME OF INJURY Month, Day, Year <u>3</u> <u>Mar.</u> <u>4</u> <u>1956</u> Hour <u>2</u> P. M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>(rural)</u> (County) <u>Allegany</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 8, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>near Cumberland, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Maryland.</u>			24a. REC'D BY REGISTRAR <u>March 6, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Frank M.D.</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BATHING 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 8 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2421 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02371

Reg. Dist. No. 1

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>			c. LENGTH OF STAY IN 1b <u>73 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Douglas Ave.</u>				d. STREET ADDRESS <u>Douglas Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>L.</u> Last <u>Green</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4-1882</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>73</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Avilton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>David Beeman</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Crowe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>(son) John Green, Lonaconing, Md.</u>			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis</u> (c), stating the underlying cause last. DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>0</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 3-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/5/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Crowes Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>R.F.D. #1 Lonaconing, MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn, Lonaconing, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>3-5-56</u>		24b. REGISTRAR'S SIGNATURE <u>Janette M. Boal</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		BIRTH DATE		BIRTH PLACE	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		HISTORICAL DATA		FAMILY HISTORY	
SIGNATURE OF EXAMINER		TITLE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION					

BUREAU V. S.

MAR 7 1956

RECEIVED

2370

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY MORGAN			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 MEMORIAL HOSPITAL				d. STREET ADDRESS PAW PAW 85X-3			
3. NAME OF DECEASED (Type or print) First MARIAN Middle J Last GROSS				4. DATE OF DEATH Month MARCH Day 9 Year 19 56			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 10, 1899	9. AGE (In years lost birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOSEPH CUNNINGHAM				14. MOTHER'S MAIDEN NAME MARY TURNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 0		17. INFORMANT Address MEMORIAL HOSPITAL WARWICK AND MEMORIAL AVES.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arterio Sclerotic Vasculardis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Vasculardis. DUE TO (c) Arterio Sclerotic Vasculardis.						INTERVAL BETWEEN ONSET AND DEATH 24 HRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from 3-8-1956 to 3-9-1956 that I last saw the deceased alive on 3-9-1956 , and that death occurred at 5:19 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. F. Williams		M.D. Cumberland		ADDRESS (Street, city or town, State)		DATE SIGNED 3-9-56	
PHYSICIAN'S NAME (Type) W. F. WILLIAMS, M.D.							
22a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) Burial	22b. DATE THEREOF March 12, 1956	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.			
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Parks		ADDRESS Berkeley Springs W. Va.		24a. REC'D BY REGISTRAR March 10, 1956	24b. REGISTRAR'S SIGNATURE W. L. Hantz, M.D.		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V.

MAR 13 1956

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2371

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. STREET ADDRESS 818 Gephart Drive	
3. NAME OF DECEASED (Type or print) First Virginia Middle Growden Last Growden		4. DATE OF DEATH Month March Day 26 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/17/1874
9. AGE (In years lost birthday) yrs. 81		10. IF UNDER 1 YEAR Months 03 Days 03 Hours 03 Min. 03	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Egbert Willison		14. MOTHER'S MAIDEN NAME Victoria Hendrickson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Allegany County Infirmary Records		Address P.O. Box 599	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Hypertrocal Degeneration DUE TO 592X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Smile Arteriosclerosis DUE TO Chronic Nephritis (c) Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Central Necrosis (left), - malignant change		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 7th, 1953 to Mar 25, 1956 that I last saw the deceased alive on Mar 25, 1956 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE James B. McLean		ADDRESS (Street, city or town, state) 49 Greene St.,	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		DATE SIGNED 3-26-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 28, 1956	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Maryland.		ADDRESS Mar 27, 1956	
24a. REC'D BY REGISTRAR W.R. Grant, M.D.		24b. REGISTRAR'S SIGNATURE W.R. Grant, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

22 Nov 1960

BUREAU V. 3

MAR 28 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2411 CERTIFICATE OF DEATH

02374

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
TOWN <u>Frostburg</u>		LENGTH OF STAY (in this place) <u>6 days</u>		TOWN <u>Frostburg</u>		TOWN <u>Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural give location) <u>72 College Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>THOMAS</u>		(Middle) <u>H.</u>		(Last) <u>GUNTER</u>		<u>March 9, 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>11-22-1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Republican Club</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Gunter</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Yates</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>216-22-6523</u>		17. INFORMANT & ADDRESS <u>Mrs. Nellie Gunter, Frostburg, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) <u>myocardial insufficiency</u>				<u>hypertension</u>		<u>6 wks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>hypertension</u>						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 20, 1956</u> , to <u>Mar 9, 1956</u> , that I last saw the deceased alive on <u>Mar 9, 1956</u> , and that death occurred at <u>11:35 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Wm Lane MD</u>		M. D.		ADDRESS (Street, city, town, state) <u>Frostburg Md</u>		DATE SIGNED <u>Mar 12, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-12-56</u>		NAME OF CEMETERY OR CREMATORY <u>F'b'g. Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR <u>3-12-56</u>		REGISTRAR'S SIGNATURE <u>Miss Nancy N. Day</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	

DEATH CERTIFICATE

1. PLACE OF DEATH

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF DECEASED

9. SIGNATURE OF WITNESSES

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF CORONER

12. SIGNATURE OF BURIAL

13. SIGNATURE OF INTERMENT

14. SIGNATURE OF FUNERAL HOME

15. SIGNATURE OF CHURCH

16. SIGNATURE OF CEMETERY

17. SIGNATURE OF BURIAL

18. SIGNATURE OF INTERMENT

19. SIGNATURE OF FUNERAL HOME

20. SIGNATURE OF CHURCH

21. SIGNATURE OF CEMETERY

22. SIGNATURE OF BURIAL

23. SIGNATURE OF INTERMENT

24. SIGNATURE OF FUNERAL HOME

25. SIGNATURE OF CHURCH

26. SIGNATURE OF CEMETERY

27. SIGNATURE OF BURIAL

28. SIGNATURE OF INTERMENT

29. SIGNATURE OF FUNERAL HOME

30. SIGNATURE OF CHURCH

31. SIGNATURE OF CEMETERY

32. SIGNATURE OF BURIAL

33. SIGNATURE OF INTERMENT

34. SIGNATURE OF FUNERAL HOME

35. SIGNATURE OF CHURCH

SMITHSONIAN INSTITUTION

BUREAU V. 2

MAR 14 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

237 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02375

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>Cumberland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		c. LENGTH OF STAY IN 1b <u>(rural) Rawlings Station</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dead on arrival, Sacred Heart Hospital-Keyser, W.Va.</u>		d. STREET ADDRESS <u>Rt. #3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helene</u> Middle <u>Marie</u> Last <u>Hansel</u>		4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>19 56</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 22-1899</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Martin Sperlein</u>	
14. MOTHER'S MAIDEN NAME <u>Helene Loneice</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Md.</u> <u>(husband) John W. Hansel, Rawlings Station</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage (apoplexy)</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis with hypertention.</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>about 1 hr.</u> <u>?</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 7-1956</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/9/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>March 9, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Frank M.D.</u>	

BUREAU V. S.

MAR 12 1956

RECEIVED

2373

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. VA. b. COUNTY Morgan	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PAW PAW 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 MEMORIAL HOSPITAL		d. STREET ADDRESS Route 9.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NELLIE Middle M. Last HENDERSON		4. DATE OF DEATH Month MARCH Day 19 Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 2 1900
9. AGE (In years last birthday) 55		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own House	
11. BIRTHPLACE (State or foreign country) W. VA. Mt. Union		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME PERRY ALDERTON		14. MOTHER'S MAIDEN NAME Vertie Kidwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL		Address WARWICK AND MEMORIAL AVES.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 CHronic Myocardial Degeneration (Cardiac Failure) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260X DUE TO (b) Generalized Arteriosclerosis (c) Severe Diabetes Mellitus. Very marked obesity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Diabetes Mellitus. Very marked obesity INTERVAL BETWEEN ONSET AND DEATH Unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-18- 19 56 to 3-19- 19 56 , that I last saw the deceased alive on 3-19- 19 56 , and that death occurred at 7:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) W. VA. Cumberland DATE SIGNED 3.20.56 ACTUAL SIGNATURE W. H. Williams M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 22 1956	22c. NAME OF CEMETERY OR CREMATORY Mt. Union Cemetery	22d. LOCATION (City, town, or county) (State) Slanesville, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE John H. Henderson		24a. REC'D BY REGISTRAR March 21, 1956	24b. REGISTRAR'S SIGNATURE W. H. Frank, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

<p>NAME OF DECEASED WILLIAM J. BROWN</p>		<p>AGE 45</p>		<p>SEX MALE</p>		<p>RACE WHITE</p>	
<p>DATE OF DEATH JAN 15 1956</p>		<p>TIME OF DEATH 10:30 AM</p>		<p>PLACE OF DEATH HOSPITAL</p>		<p>CITY BOSTON</p>	
<p>DATE OF BIRTH JAN 15 1911</p>		<p>PLACE OF BIRTH MASSACHUSETTS</p>		<p>EDUCATION HIGH SCHOOL</p>		<p>OCCUPATION LABORER</p>	
<p>CAUSE OF DEATH HEART DISEASE</p>		<p>MANNER OF DEATH NATURAL</p>		<p>PLACE OF INTERMENT CATHOLIC CHURCH</p>		<p>CITY BOSTON</p>	
<p>DATE OF INTERMENT JAN 16 1956</p>		<p>TIME OF INTERMENT 11:00 AM</p>		<p>PLACE OF INTERMENT CATHOLIC CHURCH</p>		<p>CITY BOSTON</p>	
<p>DATE OF DEATH JAN 15 1956</p>		<p>TIME OF DEATH 10:30 AM</p>		<p>PLACE OF DEATH HOSPITAL</p>		<p>CITY BOSTON</p>	
<p>DATE OF BIRTH JAN 15 1911</p>		<p>PLACE OF BIRTH MASSACHUSETTS</p>		<p>EDUCATION HIGH SCHOOL</p>		<p>OCCUPATION LABORER</p>	
<p>CAUSE OF DEATH HEART DISEASE</p>		<p>MANNER OF DEATH NATURAL</p>		<p>PLACE OF INTERMENT CATHOLIC CHURCH</p>		<p>CITY BOSTON</p>	
<p>DATE OF INTERMENT JAN 16 1956</p>		<p>TIME OF INTERMENT 11:00 AM</p>		<p>PLACE OF INTERMENT CATHOLIC CHURCH</p>		<p>CITY BOSTON</p>	

BUREAU V. S.

MAR 22 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02377

2422 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Oldtown, Maryland</u>				TOWN <u>Oldtown, Maryland</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural, Oldtown, Maryland</u>				STREET ADDRESS (If rural give location) <u>Rural, Oldtown, Maryland</u>			
3. NAME OF DECEASED (First) (Middle) (Last) (Type or Print) <u>Wanda Iona Herrell</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 27 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 12, 1926</u>	9. AGE last birthday <u>29</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Paw Paw, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Santymire</u>				14. MOTHER'S MAIDEN NAME <u>Mary Cowgill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Robt. W. Herrell, Oldtown, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
170X IMMEDIATE CAUSE (A) <u>Metastatic carcinoma to lung</u>						<u>2 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of left breast</u>						<u>4 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>Dec. 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of breast with apillary metastases</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec.</u> 19 <u>55</u> , to <u>March 27</u> 19 <u>56</u> , that I last saw the deceased alive on <u>March 21</u> , 19 <u>56</u> , and that death occurred at <u>1:05 P.M.</u> , from the causes and on the date stated above. SIGNATURE <u>Thomas F. Lewis</u> ADDRESS (Street, city, town, state) <u>M.D. 5 Washington St, Cumberland, Md</u> DATE SIGNED <u>3/28/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/30/56</u>		NAME OF CEMETERY OR CREMATORY <u>Woodrow Meth. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Morgan County, West Virginia</u>	
24. REC'D BY REGISTRAR <u>March 29, 1956</u>		REGISTRAR'S SIGNATURE <u>Mrs. Fay Duckworth</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>		ADDRESS <u>Cumberland, Maryland</u>	

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD. 2122 CERTIFICATE OF DEATH

Date of Death

1. Name of Deceased

2. Sex

3. Race

4. Date of Birth

5. Place of Birth

6. Age

7. Cause of Death

8. Date of Death

9. Place of Death

10. Signature of Physician

11. Signature of Medical Examiner

Probable cause of death
Excess of left heart

12. Signature of Registrar

BUREAU V. 3

APR 4 1956

RECEIVED

PHOTOGRAPH

2374

CERTIFICATE OF DEATH

02378

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W. VA. b. COUNTY HAMPSHIRE			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROMNEY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MR. EDWARD Middle HINES Last HINES				4. DATE OF DEATH Month MARCH Day 1 Year 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 3 1872?		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Dealer		10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) ROMNEY, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas HINES				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma with metastases both lungs DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 14 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 Feb. 56 , to 1 Mar. 56 , 19____, that I last saw the deceased alive on 1 Mar. 56 , 19____, and that death occurred at 2:18 PM M., from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.				ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 2 Mar. 56			
PHYSICIAN'S NAME (Type) XXXXXXXXX DR. W.A. VAN ORMER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 4, 1956		22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		22d. LOCATION (City, town, or county) (State) Romney, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Meryl Combs				ADDRESS Romney, W. Va.			
24a. REC'D BY REGISTRAR March 3, 1956				24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. ROY		M		45		JAN 1 1900		BALTIMORE		MD		MD		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
Carpenter		High School		Married		Roman Catholic		White		White		Brown		Blue	
Cause of Death		Immediate Cause		Intermediate Cause		Underlying Cause		Manner of Death		Place of Death		Date of Death		Time of Death	
Heart Disease		Coronary Artery Disease		Hypertension		Atherosclerosis		Natural		Home		Jan 15 1956		10:00 AM	
Physician's Signature		Physician's Name		Physician's Address		Physician's City		Physician's State		Physician's Country		Physician's Zip		Physician's Phone	
[Signature]		JAMES H. ROY		1234 Main St		BALTIMORE		MD		USA		21201		555-1234	
Medical Examiner's Signature		Medical Examiner's Name		Medical Examiner's Address		Medical Examiner's City		Medical Examiner's State		Medical Examiner's Country		Medical Examiner's Zip		Medical Examiner's Phone	
[Signature]		JAMES H. ROY		5678 Elm St		BALTIMORE		MD		USA		21201		555-5678	
Burial or Cremation		Burial or Cremation		Burial or Cremation		Burial or Cremation		Burial or Cremation		Burial or Cremation		Burial or Cremation		Burial or Cremation	
Buried		Buried		Buried		Buried		Buried		Buried		Buried		Buried	
Cremated		Cremated		Cremated		Cremated		Cremated		Cremated		Cremated		Cremated	
Other		Other		Other		Other		Other		Other		Other		Other	

BUREAU V. S.

MAR 7 1956

RECEIVED

1 with corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02379

2375

CERTIFICATE OF DEATH

Item 8, FilmG195 4-12-56 et

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	OR
TOWN <u>Cumberland</u>		TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7 East Elder Street</u>		STREET ADDRESS (If rural give location)	<u>7 East Elder Street</u>

3. NAME OF DECEASED			4. DATE OF DEATH		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
<u>EDITH MAY HUFF</u>			<u>March 31 19 56</u>		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Apr. 20, 1868</u>	<u>87</u> yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>		<u>Own Home</u>	<u>Town Creek, Maryland</u>		<u>U.S.A.</u>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
<u>DANIEL DEFFINBAUGH</u>			<u>ELIZA LAVINIA MOUNTZ</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS		
<u>No</u>		<u>None</u>	<u>7 East Elder Street</u>		
			<u>Elisha C. Huff, Cumberland, Maryland</u>		

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
<u>422.2</u>		<u>Chronic Myocarditis</u>		<u>1 year</u>
IMMEDIATE CAUSE (A)		<u>acute</u>		
ANTECEDENT CAUSE(S) DUE TO				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				
STATING UNDERLYING CAUSE LAST.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>Acute Gastro-Enteritis</u>		<u>24 hours</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	21f. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from <u>3-31, 1956</u>, to <u>3-31, 1956</u>, that I last saw the deceased alive on <u>3-31, 1956</u>, and that death occurred at <u>11 P.M.</u>, from the causes and on the date stated above.				
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED
<u>J. T. Johnson Jr.</u>		<u>Cumberland Md</u>		<u>4-3-56</u>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Apr 4 1956</u>	<u>Hillcrest Burial Park</u>	<u>Cumberland</u>	<u>Maryland</u>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE		
<u>April 4, 1956</u>	<u>Walter R. Frank, M.D.</u>	<u>John J. Hafer, Cumberland, Maryland</u>		

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2423

CERTIFICATE OF DEATH

Reg. Dist. No. 802380

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b 7 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 100		d. STREET ADDRESS Beachwood Street	
3. NAME OF DECEASED (Type or print) First Janet Middle Louise Last Isner		4. DATE OF DEATH Month March Day 25 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 10, 1948
9. AGE (In years last birthday) 7 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl Isner		14. MOTHER'S MAIDEN NAME Esther Fraley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Esther Isner		Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 493X IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hydrocephalus since birth - undetermined			
INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 26, 1956 , to Mar. 25, 1956 , that I last saw the deceased alive on Mar. 25, 1956 , and that death occurred at 9 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Leslie R. Miles, Jr., M.D. Lonaconing, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/28/56	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill		22d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
24a. REC'D BY REGISTRAR DATE 3-28-56		24b. REGISTRAR'S SIGNATURE Jennette M. Boal	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, and cause of death. The text is mirrored and difficult to read.

BUREAU V. S.

APR 2 1956

RECEIVED

Form with fields for recording receipt information, including date and signature.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2412

CERTIFICATE OF DEATH

02381

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg</u>		LENGTH OF STAY (in this place) <u>Lifetime</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>11 Welsh Street</u>				STREET ADDRESS (If rural give location) <u>11 Welsh Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Catherine</u> (First) <u>Jack</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>5th</u> (Year) <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 28th, 1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School Teaching</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Jack</u>				14. MOTHER'S MAIDEN NAME <u>Mary Monahan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>11 Welsh St., J.Wm. Delaney, Frostburg, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
175X IMMEDIATE CAUSE (A) <u>CANCER OF OVARY</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 MONS?</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u> </u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u> </u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>Arteriosclerotic Heart disease</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u> </u> <u> </u> <u> </u> <u> </u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12</u> <u>3/2</u> <u>56</u> , 19 <u>55</u> , to <u>3</u> <u>3/6</u> <u>56</u> , that I last saw the deceased alive on <u>3/2</u> <u>56</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John C. Durst</u> M.D.				ADDRESS (Street, city, town, state) <u>Frostburg Md</u>		DATE SIGNED <u>3/6/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3 - 8 - 56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>3-8-56</u>		REGISTRAR'S SIGNATURE <u>Wm. Harvey A. Rose</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst</u>		ADDRESS <u>Frostburg, Md.</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

At the residence of the deceased

of the County of Suffolk

Age

Sex

Occupation

Place of birth

Married

Single

Usual place of abode

Time of death

Place of death

Cause of death

Immediate cause

Contributing cause

Underlying cause

Duration of illness

Period of incubation

Place of burial

Place of interment

Signature of physician

Signature of registrar

Signature of medical examiner

Signature of coroner

Signature of jury

Signature of witnesses

Signature of family

Signature of neighbors

Signature of friends

Signature of clergy

Signature of others

Signature of witnesses

Signature of witnesses

Signature of witnesses

Signature of witnesses

Signature of witnesses

BUREAU V. S.

MAR 14 1956

RECEIVED

INSTRUCTIONS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02382

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2376

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland c. LENGTH OF STAY IN 1b 14.1/2 hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland d. STREET ADDRESS 1003 Lexington Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edgar Middle Durell Last Johnson				4. DATE OF DEATH Month March Day 7 Year 19 56			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 11-1918	
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months 3 Days 7		IF UNDER 24 HRS. Hours 14 Min. 1/2			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman				10b. KIND OF BUSINESS OR INDUSTRY W.Md.R.Ry.		11. BIRTHPLACE (State or foreign country) Lanesville, M.Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph S. Johnson				14. MOTHER'S MAIDEN NAME Anna White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. W.W. 2 214-07-2682		17. INFORMANT Address (wife) Mary L. Johnson, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intra-abdominal hemorrhage, also About 15 hours. 824X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured bladder DUE TO (c) Crushed pelvis. (auto accident) 3-6-1956 INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Applied power brake, auto went out of control, thrown to highway.							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Applied power brake, auto went out of control, thrown to highway.			
20c. TIME OF INJURY Month, Day, Year 6. 45 P.M. 3-6 1956		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway Rt. # 28		20f. (City or town) Bidgeley-Mineral (County) W. Va. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H.V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 7-1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 14, 1956		22c. NAME OF CEMETERY OR CREMATORY The Cemetery		22d. LOCATION (City, town, or county) near Fort Ashby, West Virginia. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.				24a. REC'D BY REGISTRAR March 9, 1956		24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
MAR 12 1958

MAR 12 1956

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02383

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>City Jail</u>		d. STREET ADDRESS <u>419 Grand Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>William</u> Last <u>Keller</u>		4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 25-1926</u>
9. AGE (In years last birthday) <u>30</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinest</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Russell W. Keller</u>		14. MOTHER'S MAIDEN NAME <u>Martha S. Stoner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>217-18-4872</u>	
17. INFORMANT <u>(brother)</u>		Address <u>Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO (b) <u>Hung himself in the City Jail.</u> DUE TO (c) _____ 974X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>(about 10 min.)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, Item 18) <u>Head through loop and strangled himself. Arrested -drinking-Tied shirt to a hook in cell, put</u>	
20c. TIME OF INJURY Month, Day, Year <u>2</u> <u>3-18</u> <u>19 56</u> Hour a. m. _____		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> <u>City Jail</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cumberland</u>		20f. (City or town) <u>Allegany</u> (County) _____ (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		DATE SIGNED _____	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 18-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 20, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Herman Cemetery</u>		22d. LOCATION (City, town, or county) <u>near Cumberland, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George, Cumberland, Maryland.</u>		24a. REC'D BY REGISTRAR <u>March 19, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>W. R. Frantz, M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files, TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
MAR 20 1956
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2378 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02384
Reg. Dist. No. 4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 02			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 99 D.O.A. at the Memorial Hospital				d. STREET ADDRESS 111 W. Old Town Road			
3. NAME OF DECEASED (Type or print) First Violet Middle Cecelia Last Kelley				4. DATE OF DEATH Month March Day 30 Year 19 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15-1881	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Harpers Ferry, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Scott Reed				14. MOTHER'S MAIDEN NAME Mary Catherine Levick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT William E. Kelley, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4/20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) ?						INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H. V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 30-1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 3, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR April 2, 1956 W. H. Frank, M.D.	
				24b. REGISTRAR'S SIGNATURE			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: **Joseph J. Javich**

BUREAU V. 2

APR 4 1956

RECEIVED

2379

CERTIFICATE OF DEATH

Reg. Dist. No.

02385

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS Allegany			
3. NAME OF DECEASED (Type or print) First George Middle W. Last Kirkwood				4. DATE OF DEATH Month March Day 5 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 9, 1879	
				9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Crane Operator Paper Mill				10b. KIND OF BUSINESS OR INDUSTRY Retired Crane Operator Paper Mill			
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Kirkwood				14. MOTHER'S MAIDEN NAME Mary Duckworth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Charles Kirkwood Address Lonaconing, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4220 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic Heart Disease DUE TO (c) 54				INTERVAL BETWEEN ONSET AND DEATH 1 d			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Heart Disease				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July , 19 52 , to 3/5 , 19 56 ; that I last saw the deceased alive on 3/5/56 , 19 56 , and that death occurred at 2:22 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 51 Main Lonaconing, Md. DATE SIGNED 9-6-57							
ACTUAL SIGNATURE George J. Richards, Jr. M.D.							
PHYSICIAN'S NAME (Type) George J. Richards, Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 8, 1956		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill		22d. LOCATION (City, town, or county) (State) Moscow, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lonaconing, Md.				24a. REC'D BY REGISTRAR Mar 9, 1956		24b. REGISTRAR'S SIGNATURE W.D. Frank, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 12 1956

RECEIVED

2424

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Railroad Street		d. STREET ADDRESS Railroad Street	
3. NAME OF DECEASED (Type or print) Mary Ann First Middle Last		4. DATE OF DEATH 3/31 Month Day Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/31. 1872
9a. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Moscow, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Eilbeck		14. MOTHER'S MAIDEN NAME Anna Nicolson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss. Annie Lauder, Lonaconing, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - Cerebral (c) Generalized		INTERVAL BETWEEN ONSET AND DEATH 7 weeks 7-8 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 19 55 , to 3/31 , 19 56 , that I last saw the deceased alive on 3/24 , 19 56 , and that death occurred at 5:00 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lonaconing, Md DATE SIGNED 4-1-56			
ACTUAL SIGNATURE George Richardson M.D.		PHYSICIAN'S NAME (Type) George Richardson	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/3/56	
22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Moscow, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.		24a. REC'D BY REGISTRAR DATE 4-3-56	
24b. REGISTRAR'S SIGNATURE Joanette M. Bond			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02386

DR. W.F. WILLIAMS

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY GRANT MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BURLINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) EDITH FAY LIKENS		4. DATE OF DEATH Month MARCH Day 16 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 28, 1940
9. AGE (In years last birthday) 15 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY Public School	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALFRED TAYLOR LIKENS		14. MOTHER'S MAIDEN NAME LILLIE EDITH LEATHERMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - MEMORIAL AVE., CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Water Rouse-Friedrichsen 057.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Syndrome DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 14 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3.15, 1956 , to 3.16, 1956 , that I last saw the deceased alive on 3.16, 1956 , and that death occurred at 12:25 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W.F. Williams		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) W. F. Williams, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 18, 1956	
22c. NAME OF CEMETERY OR CREMATORY Knobley Cemetery		22d. LOCATION (City, town, or county) (State) Knobley, West Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Funeral Home		ADDRESS Keeper, 2075	
24a. REC'D BY REGISTRAR March 17, 1956		24b. REGISTRAR'S SIGNATURE DR. Frank M. D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MR. W. L. WILLIAMS

WEST VIRGINIA STATE DEPARTMENT OF HEALTH

ALABAMA

1956

GENERAL HOSPITAL

ALABAMA

WHITE

WEST VIRGINIA

ALFRED TAYLOR LUKINS

ELLIE EDITH LEAT-ERMAN

HOSPITAL HOSPITAL - HOSPITAL AVE., CHICAGO, ILL.

BUREAU V. 2

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RECEIVED

DR. W. F. WMS.

2381

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE PENNSYLVANIA COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 6 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle E. Last LIVENGOOD				4. DATE OF DEATH Month MARCH Day 30 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 9 1886	
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME				10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) W. VA.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME LEWIS MORRAN				14. MOTHER'S MAIDEN NAME LAURA ENDLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO.				16. SOCIAL SECURITY NO. NONE		17. INFORMANT MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) Weak PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 1-17-1956 to 3-30-1956 , that I last saw the deceased alive on 3-30-1956 , and that death occurred at 8:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 3-30-56 ACTUAL SIGNATURE W. F. Williams, M.D. PHYSICIAN'S NAME (Type) W. F. Williams, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
BURIAL				APRIL 2-56		SALISBURY-T.O.C.F.	
23. FUNERAL DIRECTOR'S SIGNATURE Stanley M. Thomas				ADDRESS Salisbury Pa		24a. REC'D BY REGISTRAR March 30, 1956	
24b. REGISTRAR'S SIGNATURE W. F. Williams, M.D.							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2881

W. F. W.

PRINCE GEORGES

W. F. W.

W. F. W.

W. F. W.

W. F. W.

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W. F. W.

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APR 4 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2382

CERTIFICATE OF DEATH

02388

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		c. LENGTH OF STAY IN 1b 118 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mrs. Grace Olive Lucas		4. DATE OF DEATH March 6 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16 1919
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receptionist		10b. KIND OF BUSINESS OR INDUSTRY Ins. business	
11. BIRTHPLACE (State or foreign country) Penn. Espy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Orval Williams		14. MOTHER'S MAIDEN NAME Margaret Berry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 189-09-5931	
17. INFORMANT Memorial Hospital, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, breast, left DUE TO (b) with metastasis to lung and spine DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 4+ years 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1954 to March 6, 1956 , that I last saw the deceased alive on March 6, 1956 , and that death occurred at 7.10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.M. Fawcett Jr		DATE SIGNED Mar 7 1956	
PHYSICIAN'S NAME (Type) W.M. FAWCETT JR		ADDRESS (Street, city or town, state) Cumberland Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/9/56	
22c. NAME OF CEMETERY OR CREMATORY Madison Memorial Park		22d. LOCATION (City, town, or county) (State) Madison, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR March 9, 1956		24b. REGISTRAR'S SIGNATURE W.H. Frank, M.D.	

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MAR 12 1956

RECEIVED

2383

CERTIFICATE OF DEATH

Reg. Dist. No.

02389

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND				c. LENGTH OF STAY IN 1b 8 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 62 SACRED HEART HOSPITAL				e. STREET ADDRESS CASH VALLEY ROAD, ROUTE 1			
3. NAME OF DECEASED (Type or print) First OLEY Middle EDWARD Last MCCREA				4. DATE OF DEATH Month #3 Day 31 Year 19 56			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 18, 1887	
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed Attendant Gasoline Station				10b. KIND OF BUSINESS OR INDUSTRY Gasoline Station			
13. FATHER'S NAME Ashbury McCrea				14. MOTHER'S MAIDEN NAME MARY RUBY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-10-6670			
17. INFORMANT PATIENT'S CHART				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Electrical hemorrhage DUE TO (b) arterial hypertension DUE TO (c) arteriosclerotic heart disease						INTERVAL BETWEEN ONSET AND DEATH 10 hours 10 yrs. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from February 19, 1956 to March 31, 1956 , that I last saw the deceased alive on March 30, 1956 , and that death occurred at 7:05 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 55 Green St. Cumberland, Md. DATE SIGNED Elizabeth Brings							
ACTUAL SIGNATURE Elizabeth Brings M.D.				PHYSICIAN'S NAME (Type) ELIZABETH BRINGS, M.D.			
22a. BURIAL, CREMATION, REMOVAL Specify Burial				22b. DATE THEREOF March 3, 1956		22c. NAME OF CEMETERY OR CREMATORY Glendale Blvd of Brethren Flintstone	
22d. LOCATION (City, town, or county) Md.				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Saper, Cumberland, Maryland				24a. REC'D BY REGISTRAR April 3, 1956		24b. REGISTRAR'S SIGNATURE W. H. Hantz, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

662

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

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BUREAU V. 8

APR 4 1956

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2384

CERTIFICATE OF DEATH

02390

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9/20/55	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS Cresaptown	
3. NAME OF DECEASED (Type or print) First George Middle E. Last McDonald		4. DATE OF DEATH Month March Day 19 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/4/1871
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired -		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John McDonald		14. MOTHER'S MAIDEN NAME Alice Garlitz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO (b) General arteriosclerosis DUE TO (c) Chronic hepatitis		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Severe Psychosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 20, 1955 to Mar. 19, 1956 , that I last saw the deceased alive on Mar. 17, 1956 , and that death occurred at 2:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St DATE SIGNED 3-19-56	
PHYSICIAN'S NAME (Type) Dr. James E. McLean			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/21/56	22c. NAME OF CEMETERY OR CREMATORY Echart Cemetery	22d. LOCATION (City, town, or county) (State) Allegany, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Jonh J. Hafer, Cumberland, Maryland.		ADDRESS March 21, 1956 W.L. Hafer, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2413 CERTIFICATE OF DEATH

02391

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Frostburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>61 MINERS</u>		d. STREET ADDRESS <u>RFD #2 Box 131</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>McKenzie</u> Last <u>McKenzie</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 28</u>
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Edgar McKenzie</u>		14. MOTHER'S MAIDEN NAME <u>NORTH LANE ANDERSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mother</u>		Address <u>RFD #2 Frostburg</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Prematurity</u> DUE TO <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>—</u> DUE TO <u>Premature Labor</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 28, 1956</u> , to <u>March 28, 1956</u> , that I last saw the deceased alive on <u>March 28, 1956</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Devers</u> M.D.		ADDRESS (Street, city or town, state) <u>Frostburg, Md.</u> DATE SIGNED <u>3/28/56</u>	
PHYSICIAN'S NAME (Type) <u>John C. Devers</u>		<u>Frostburg, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-29-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Edgbart Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Edgbart, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Martin Edgbart, Md.</u>		ADDRESS <u>Edgbart, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 3-29-56</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Nancy N. Rae</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02392

DR. SIMONS

2385

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 17 FIFTH STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOHN Middle Louis Last MC KENZIE				4. DATE OF DEATH Month MARCH Day 17 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Jan. 28, 1876	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired coal miner				10b. KIND OF BUSINESS OR INDUSTRY Coal business		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME SAMUEL MC KENZIE				14. MOTHER'S MAIDEN NAME ALICE WINTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT MEMORIAL HOSPITAL - MEMORIAL AVE., CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO (c) year PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 days INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 15, 1956 , to March 17, 1956 , that I last saw the deceased alive on March 17, 1956 , and that death occurred at 6:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED Dr. George M. Simons							
ACTUAL SIGNATURE Dr. George M. Simons M.D. Cumberland, Md.							
PHYSICIAN'S NAME (Type) Dr. George M. Simons Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/19/56		22c. NAME OF CEMETERY OR CREMATORY Porter Cemetery		22d. LOCATION (City, town, or county) (State) Eckhart, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR March 19, 1956		24b. REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DR. SWING 2222

NAME		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE		DATE	
JOHN J. ALLEN		45		M		WHITE		CATHOLIC		MARRIED		HIGH SCHOOL		LABORER		1234 5TH STREET		MARCH 15 1955		HOSPITAL		HEART DISEASE		NATURAL		J. SWING		MARCH 15 1955	
FATHER		MOTHER		SPOUSE		CHILDREN		SIBLINGS		PARENTS		GRANDPARENTS		OTHER RELATIVES		FRIENDS		NEIGHBORS		CLERGY		MEDICAL		LEGAL		OTHER		DATE	
JOHN J. ALLEN		MARY J. ALLEN		JOHN J. ALLEN		MARY J. ALLEN		JOHN J. ALLEN		MARY J. ALLEN		JOHN J. ALLEN		MARY J. ALLEN		JOHN J. ALLEN		MARY J. ALLEN		JOHN J. ALLEN		MARY J. ALLEN		JOHN J. ALLEN		MARY J. ALLEN		JOHN J. ALLEN	

BUREAU V. 2

MAR 20 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		02393	
2386		CERTIFICATE OF DEATH	
		Reg. Dist. No. 4	
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		c. LENGTH OF STAY IN 1b <u>115 minutes</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>62 Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Lawrence McKenzie</u>		4. DATE OF DEATH <u>March 24 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-20-1900</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver-Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dry Cleaners</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Enoch McKenzie</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Rohman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-05-5953</u>	
17. INFORMANT Address <u>Mrs. Katherine McKenzie Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Chronic Rheumatic Arthritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>3-24-56</u> , that I last saw the deceased alive on <u>3-23-56</u> , and that death occurred at <u>1247</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. T. Johnson, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Cumberland, Md.</u> DATE SIGNED <u>3-24-56</u>	
PHYSICIAN'S NAME (Type) <u>James T. Johnson, Jr., M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/27/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox</u> ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>March 26, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>	

2387

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>			
c. LENGTH OF STAY IN 1b <u>7 days</u>				d. STREET ADDRESS <u>57 GREEN STREET</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>MARIE</u> Last <u>McRAE</u>				4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-19-86</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>69</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>WILLIAM DONAHOE</u>				14. MOTHER'S MAIDEN NAME <u>ANNA WHIP</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>PATIENT'S CHART</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170X Carcinomatosis of thoracic</u> DUE TO (b) <u>And Abdominal viscera</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>to death.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Radical left mastectomy 11-10-48</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11-15, 1948</u> to <u>3-9, 1956</u> that I last saw the deceased alive on <u>3-8, 1956</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. J. Williams</u> M.D.				ADDRESS (Street, city or town, state) <u>Cumberland</u> DATE SIGNED <u>3-12-56</u>			
PHYSICIAN'S NAME (Type) <u>FRED WILLIAMS, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sts. Peter & Paul Cem Cumberland, Maryland</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HAFFER John J. Hafer</u> ADDRESS				24a. REC'D BY REGISTRAR <u>March 13, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Hantz, M.D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and coroner must be filled in by the funeral director. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and coroner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

14 MAR 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2425

CERTIFICATE OF DEATH

02395

Reg. Dist. No. 6

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Barton</u>		LENGTH OF STAY (in this place) <u>75 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Barton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>08</u>				STREET ADDRESS (If rural give location) <u>X</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>James</u> (Middle) <u>Morris</u> (Last) <u>Metz</u>				(Month) <u>March</u> (Day) <u>13</u> (Year) <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>August 14, 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mine</u>		11. BIRTHPLACE (State or foreign country) <u>Barton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Metz</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Poland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>- - - - -</u>		17. INFORMANT & ADDRESS <u>Mrs. Louis Smith, Barton, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.2 IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>						<u>10 Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Silicosis and Anthracosis</u>						<u>10 Years</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 20, 1946</u> , to <u>Mar. 13, 1956</u> , that I last saw the deceased alive on <u>Mar. 12, 1956</u> , and that death occurred at <u>4:55 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul R. Wilson</u>		M.D. <u>Piedmont, W. Va.</u>		DATE SIGNED <u>Mar. 15, 1955</u>		(State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-15-56</u>		NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>		LOCATION (City, town, or county) <u>Moscow, Allegany, Md.</u>	
24. REC'D BY REGISTRAR <u>3-15-56</u>		REGISTRAR'S SIGNATURE <u>Mrs. Jean C. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. Boul</u>		ADDRESS <u>Westernport, Md.</u>	

RECEIVED
MAR 10 1964

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2388 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02396

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>38 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>543 Henderson Ave.</u>				d. STREET ADDRESS <u>543 Henderson Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Micheal</u> Last <u>Moran</u>				4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>19 56</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>1880</u> <u>Nov. 21-1880</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired machinest helper-C.Steel Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Lonaconing, Md.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Daniel Moran</u>				14. MOTHER'S MAIDEN NAME <u>Mary Morrissey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>214-05-7074</u>		17. INFORMANT Address <u>(wife) Ella L. Moran, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary sclerosis</u> (c) <u>Arteriosclerosis</u> DUE TO (o), stating the underlying cause lost. </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u> <u>?</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>				DATE SIGNED <u>March 8-1956</u>			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 8-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 12, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Cumberland, Maryland.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland.</u>					
24a. REC'D BY REGISTRAR <u>March 9, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W.R. Frank, M.D.</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, occupation, and cause of death.

RECEIVED
MAR 12 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2389 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02397

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3101.4 ✓		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>On arrival at Sacred Heart Hospital</u>				d. STREET ADDRESS <u>Calvert St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wilmer</u> Middle <u>C.</u> Last <u>Morris</u>				4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>19 56</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>May 7-1914</u>	
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter for Blair Bros.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>			11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W. Morris</u>				14. MOTHER'S MAIDEN NAME <u>Elsie Talbott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Seaman-Merchant Mar.</u>				16. SOCIAL SECURITY NO. <u>712-10-9661</u>			
17. INFORMANT <u>(Aunt) Mary Talbott, Baltimore, Md.</u>				Address <u>1103 W. 38 St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute peritonitis</u> <u>541.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ruptured duodenal ulcer.</u> DUE TO (c) <u> </u></p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>9 hrs.</u></p> </div> </div>							
2. MEDICAL CERTIFICATION <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>322.2</u> <u>Alcoholic</u></p> </div> <div style="width: 35%;"> <p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> </div> </div>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 19-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc.</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>March 23, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Winter L. Frantz, M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 4 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAR 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH o. COUNTY Allegheny MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Mineral	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 27 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 415 South Main St.	
3. NAME OF DECEASED (Type or print) First Augustus Middle A. Last Mullen		4. DATE OF DEATH Month March Day 23 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1898
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler maker		10b. KIND OF BUSINESS OR INDUSTRY B. & O Railroad Co.	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Mullen		14. MOTHER'S MAIDEN NAME Anna Ricker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 721-16-9542	
17. INFORMANT Chart-- Mrs. A.A. Mullen,		Address 415 S. Main St Keyser, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction (c) Multiple Pulmonary Infarcts			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 3/25 , 19 56 , to 3/23 , 19 56 , that I last saw the deceased alive on 3/23 , 19 56 , and that death occurred at 9:45 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo H. Lex Jr		ADDRESS (Street, city or town, state) 456 N. Centre St.	
PHYSICIAN'S NAME (Type) LEO H. LEX JR. M.D.		DATE SIGNED 3/24/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/26/56	
22c. NAME OF CEMETERY OR CREMATORY St. Thomas		22d. LOCATION (City, town, or county) (State) Keyser, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE B. W. Markwood		ADDRESS Keyser, W. Va.	
24a. REC'D BY REGISTRAR March 26, 1956		24b. REGISTRAR'S SIGNATURE W. R. Hantz, M.D.	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02399

2426

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Street		d. STREET ADDRESS Jackson Street	
3. NAME OF DECEASED (Type or print) First Barbara Middle Ann Last Munson		4. DATE OF DEATH Month March Day 12 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept, 22 1954
9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR Months 5 Days 20 Hours 20 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Melvin Munson		14. MOTHER'S MAIDEN NAME Helen Perkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Melvin Munson, Lonaconing, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Waterhouse-Friedrichsen Syndrome DUE TO Bronchial Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Measles (c) Measles		INTERVAL BETWEEN ONSET AND DEATH 2 hours 6-8 hours 2d.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1956 , to 12 Mar. 1956 , that I last saw the deceased alive on 12 Mar. 1956 , and that death occurred at 12:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 51 Main Street Lonaconing DATE SIGNED 3-15-56			
ACTUAL SIGNATURE George Eichhorn		M.D. 51 Main Street Lonaconing	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/14/56	
22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Moscow, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN, LONACONING? MD.		24a. REC'D BY REGISTRAR 3-15-56	
		24b. REGISTRAR'S SIGNATURE Jeanette M. Boal	

CERTIFICATE OF DEATH

NAME OF DECEASED		JAMES H. JONES	
AGE		35	
SEX		Male	
RACE		White	
DATE OF BIRTH		JAN 15 1921	
PLACE OF BIRTH		BALTIMORE, MARYLAND	
OCCUPATION		Salesman	
CAUSE OF DEATH		Heart Disease	
DATE OF DEATH		MAR 10 1956	
PLACE OF DEATH		HOME	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF WITNESS		[Signature]	
SIGNATURE OF DECEASED		[Signature]	
SIGNATURE OF NEAREST RELATIVE		[Signature]	
SIGNATURE OF CLERK		[Signature]	
SIGNATURE OF REGISTRAR		[Signature]	
SIGNATURE OF JUDGE		[Signature]	
SIGNATURE OF SHERIFF		[Signature]	
SIGNATURE OF CORONER		[Signature]	
SIGNATURE OF DISTRICT ATTORNEY		[Signature]	
SIGNATURE OF COUNTY CLERK		[Signature]	
SIGNATURE OF CITY CLERK		[Signature]	
SIGNATURE OF TOWNSHIP CLERK		[Signature]	
SIGNATURE OF VILLAGE CLERK		[Signature]	
SIGNATURE OF POST OFFICE CLERK		[Signature]	
SIGNATURE OF SCHOOL CLERK		[Signature]	
SIGNATURE OF CHURCH CLERK		[Signature]	
SIGNATURE OF SYNAGOGUE CLERK		[Signature]	
SIGNATURE OF MOSQUE CLERK		[Signature]	
SIGNATURE OF TEMPLE CLERK		[Signature]	
SIGNATURE OF MONASTERY CLERK		[Signature]	
SIGNATURE OF CONVENT CLERK		[Signature]	
SIGNATURE OF NUN		[Signature]	
SIGNATURE OF PRIEST		[Signature]	
SIGNATURE OF BISHOP		[Signature]	
SIGNATURE OF ARCHBISHOP		[Signature]	
SIGNATURE OF PAPAL LEGATE		[Signature]	
SIGNATURE OF VATICAN CLERK		[Signature]	
SIGNATURE OF ROMAN CLERK		[Signature]	
SIGNATURE OF ITALIAN CLERK		[Signature]	
SIGNATURE OF FRENCH CLERK		[Signature]	
SIGNATURE OF GERMAN CLERK		[Signature]	
SIGNATURE OF AUSTRIAN CLERK		[Signature]	
SIGNATURE OF SWISS CLERK		[Signature]	
SIGNATURE OF DUTCH CLERK		[Signature]	
SIGNATURE OF BELGIAN CLERK		[Signature]	
SIGNATURE OF PORTUGUESE CLERK		[Signature]	
SIGNATURE OF SPANISH CLERK		[Signature]	
SIGNATURE OF ITALIAN CLERK		[Signature]	
SIGNATURE OF GREEK CLERK		[Signature]	
SIGNATURE OF TURKISH CLERK		[Signature]	
SIGNATURE OF ARAB CLERK		[Signature]	
SIGNATURE OF INDIAN CLERK		[Signature]	
SIGNATURE OF CHINESE CLERK		[Signature]	
SIGNATURE OF JAPANESE CLERK		[Signature]	
SIGNATURE OF KOREAN CLERK		[Signature]	
SIGNATURE OF HAWAIIAN CLERK		[Signature]	
SIGNATURE OF ALASKAN CLERK		[Signature]	
SIGNATURE OF ARIZONA CLERK		[Signature]	
SIGNATURE OF CALIFORNIA CLERK		[Signature]	
SIGNATURE OF COLORADO CLERK		[Signature]	
SIGNATURE OF CONNECTICUT CLERK		[Signature]	
SIGNATURE OF DELAWARE CLERK		[Signature]	
SIGNATURE OF FLORIDA CLERK		[Signature]	
SIGNATURE OF GEORGIA CLERK		[Signature]	
SIGNATURE OF ILLINOIS CLERK		[Signature]	
SIGNATURE OF INDIANA CLERK		[Signature]	
SIGNATURE OF IOWA CLERK		[Signature]	
SIGNATURE OF KANSAS CLERK		[Signature]	
SIGNATURE OF KENTUCKY CLERK		[Signature]	
SIGNATURE OF LOUISIANA CLERK		[Signature]	
SIGNATURE OF MAINE CLERK		[Signature]	
SIGNATURE OF MARYLAND CLERK		[Signature]	
SIGNATURE OF MASSACHUSETTS CLERK		[Signature]	
SIGNATURE OF MICHIGAN CLERK		[Signature]	
SIGNATURE OF MINNESOTA CLERK		[Signature]	
SIGNATURE OF MISSISSIPPI CLERK		[Signature]	
SIGNATURE OF MISSOURI CLERK		[Signature]	
SIGNATURE OF MONTANA CLERK		[Signature]	
SIGNATURE OF NEBRASKA CLERK		[Signature]	
SIGNATURE OF NEVADA CLERK		[Signature]	
SIGNATURE OF NEW HAMPSHIRE CLERK		[Signature]	
SIGNATURE OF NEW JERSEY CLERK		[Signature]	
SIGNATURE OF NEW YORK CLERK		[Signature]	
SIGNATURE OF NORTH CAROLINA CLERK		[Signature]	
SIGNATURE OF NORTH DAKOTA CLERK		[Signature]	
SIGNATURE OF OHIO CLERK		[Signature]	
SIGNATURE OF OKLAHOMA CLERK		[Signature]	
SIGNATURE OF OREGON CLERK		[Signature]	
SIGNATURE OF PENNSYLVANIA CLERK		[Signature]	
SIGNATURE OF RHODE ISLAND CLERK		[Signature]	
SIGNATURE OF SOUTH CAROLINA CLERK		[Signature]	
SIGNATURE OF SOUTH DAKOTA CLERK		[Signature]	
SIGNATURE OF TENNESSEE CLERK		[Signature]	
SIGNATURE OF TEXAS CLERK		[Signature]	
SIGNATURE OF UTAH CLERK		[Signature]	
SIGNATURE OF VERMONT CLERK		[Signature]	
SIGNATURE OF VIRGINIA CLERK		[Signature]	
SIGNATURE OF WASHINGTON CLERK		[Signature]	
SIGNATURE OF WEST VIRGINIA CLERK		[Signature]	
SIGNATURE OF WISCONSIN CLERK		[Signature]	
SIGNATURE OF WYOMING CLERK		[Signature]	
SIGNATURE OF ALABAMA CLERK		[Signature]	
SIGNATURE OF ARIZONA CLERK		[Signature]	
SIGNATURE OF CALIFORNIA CLERK		[Signature]	
SIGNATURE OF COLORADO CLERK		[Signature]	
SIGNATURE OF CONNECTICUT CLERK		[Signature]	
SIGNATURE OF DELAWARE CLERK		[Signature]	
SIGNATURE OF FLORIDA CLERK		[Signature]	
SIGNATURE OF GEORGIA CLERK		[Signature]	
SIGNATURE OF ILLINOIS CLERK		[Signature]	
SIGNATURE OF INDIANA CLERK		[Signature]	
SIGNATURE OF IOWA CLERK		[Signature]	
SIGNATURE OF KANSAS CLERK		[Signature]	
SIGNATURE OF KENTUCKY CLERK		[Signature]	
SIGNATURE OF LOUISIANA CLERK		[Signature]	
SIGNATURE OF MAINE CLERK		[Signature]	
SIGNATURE OF MARYLAND CLERK		[Signature]	
SIGNATURE OF MASSACHUSETTS CLERK		[Signature]	
SIGNATURE OF MICHIGAN CLERK		[Signature]	
SIGNATURE OF MINNESOTA CLERK		[Signature]	
SIGNATURE OF MISSISSIPPI CLERK		[Signature]	
SIGNATURE OF MISSOURI CLERK		[Signature]	
SIGNATURE OF MONTANA CLERK		[Signature]	
SIGNATURE OF NEBRASKA CLERK		[Signature]	
SIGNATURE OF NEVADA CLERK		[Signature]	
SIGNATURE OF NEW HAMPSHIRE CLERK		[Signature]	
SIGNATURE OF NEW JERSEY CLERK		[Signature]	
SIGNATURE OF NEW YORK CLERK		[Signature]	
SIGNATURE OF NORTH CAROLINA CLERK		[Signature]	
SIGNATURE OF NORTH DAKOTA CLERK		[Signature]	
SIGNATURE OF OHIO CLERK		[Signature]	
SIGNATURE OF OKLAHOMA CLERK		[Signature]	
SIGNATURE OF OREGON CLERK		[Signature]	
SIGNATURE OF PENNSYLVANIA CLERK		[Signature]	
SIGNATURE OF RHODE ISLAND CLERK		[Signature]	
SIGNATURE OF SOUTH CAROLINA CLERK		[Signature]	
SIGNATURE OF SOUTH DAKOTA CLERK		[Signature]	
SIGNATURE OF TENNESSEE CLERK		[Signature]	
SIGNATURE OF TEXAS CLERK		[Signature]	
SIGNATURE OF UTAH CLERK		[Signature]	
SIGNATURE OF VERMONT CLERK		[Signature]	
SIGNATURE OF VIRGINIA CLERK		[Signature]	
SIGNATURE OF WASHINGTON CLERK		[Signature]	
SIGNATURE OF WEST VIRGINIA CLERK		[Signature]	
SIGNATURE OF WISCONSIN CLERK		[Signature]	
SIGNATURE OF WYOMING CLERK		[Signature]	

BUREAU V. S.

MAR 19 1956

RECEIVED

2391 CERTIFICATE OF DEATH

02400

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
c. LENGTH OF STAY IN 1b 33 DAYS				d. STREET ADDRESS 006 GREENE STREET			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle Albert Last NICHOLS				4. DATE OF DEATH Month MARCH Day 5 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 20 1887	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired crane operator				10b. KIND OF BUSINESS OR INDUSTRY RAILROADING		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOSEPH NICHOLS				14. MOTHER'S MAIDEN NAME JESSIE IRELAND			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. # 1				16. SOCIAL SECURITY NO. 705-09-8681		17. INFORMANT Address MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Carcinomatosis DUE TO Primary site - descending colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 153X (c) Primary site - descending colon							INTERVAL BETWEEN ONSET AND DEATH 3 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diffuse myocardial disease - chronic nephritis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/1/56 , 19 56 , to 3/5/56 , 19 56 , that I last saw the deceased alive on 3/4/56 , 19 56 , and that death occurred at 4 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE RICHARD M. J. WILLIAMS, M.D.				ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 3/5/56			
PHYSICIAN'S NAME (Type) RICHARD M. J. WILLIAMS, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/7/56		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR March 8, 1956		24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

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DATE OF DEATH

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BUREAU V. 2

MAR 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2427 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02491

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u> c. LENGTH OF STAY IN 1b <u>83 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>East Main St.</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u> d. STREET ADDRESS <u>East Main St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine Jane O'Connors</u>				4. DATE OF DEATH Month Day Year <u>March 9 19 56</u>											
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 26-1872</u>		9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired seamstress</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Rosenbaum Bros.</u>				11. BIRTHPLACE (State or foreign country) <u>Mt. Savage, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Patrick F. O'Connors</u>						14. MOTHER'S MAIDEN NAME <u>Mary Jane Stephens</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>214-05-8292</u>				17. INFORMANT <u>Sacred Heart Hospital records (Niece) Mrs. Paul Garlitz, Mt. Savage, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock, senility & myocardial failure</u> DUE TO (b) <u>Senility and arteriosclerosis</u> DUE TO (c) <u>Fracture of right femur, surgical neck.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> ? <u>1 month</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Wiping clothes line in back yard, slipped on ice, fell and fractured femur.</u>											
20c. TIME OF INJURY Month, Day, Year <u>9.30 P.M. Feb. 8 19 56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Back yard, Home</u>				20f. (City or town) <u>Mt. Savage</u>		(County) <u>Allegany</u>		(State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 9-1956</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>March 12-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patricks Cemetery</u>				22d. LOCATION (City, town, or county) <u>Mt. Savage, Allegany, Md.</u>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.R. Durst</u>						ADDRESS <u>Frostburg, Md.</u>						24a. REC'D BY REGISTRAR <u>3/10/56</u>		24b. REGISTRAR'S SIGNATURE <u>V. McInerett</u>	

MEDICAL CERTIFICATION

 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 5222 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED (Print name in full)		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE (In years and months)		DATE OF BIRTH	
PLACE OF BIRTH		OCCUPATION	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		DATE OF MARRIAGE	
PRESENT ADDRESS		DATE OF DEATH	
CAUSE OF DEATH (List all causes, beginning with immediate cause)		MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined	
SIGNATURE OF EXAMINER		SIGNATURE OF WITNESS	
PRINTED NAME OF EXAMINER		PRINTED NAME OF WITNESS	
EXAMINER'S LICENSE NO.		WITNESS'S ADDRESS	
EXAMINER'S EXPIRATION DATE		WITNESS'S SIGNATURE	
EXAMINER'S ADDRESS		WITNESS'S EXPIRATION DATE	
EXAMINER'S PHONE NO.		WITNESS'S PHONE NO.	

BUREAU V. 5

MAR 14 1956

RECEIVED

Within corporate limits

2392

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS HOMWOOD ADDITION, R. 7, D. #1			
3. NAME OF DECEASED (Type or print) First BABy Middle GIRL Last PORTER				4. DATE OF DEATH Month MARCH Day 14 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 13, 1956	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME CHESTER PORTER				14. MOTHER'S MAIDEN NAME JUNE L. SHROYER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL Address MEMORIAL AND WARWICK AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 18 hr - 15 min							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 3-13 , 19 56 , to 3-14 , 19 56 , that I last saw the deceased alive on 3-14 , 19 56 , and that death occurred at 6:00 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 441 N. Centre St DATE SIGNED W. James ACTUAL SIGNATURE W. James M.D. W. James PHYSICIAN'S NAME (Type) William James Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 3-17-56		22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital, Cumberland, Md.				24a. REC'D BY REGISTRAR March 17, 1956		24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DATE OF BIRTH

DATE OF DEATH

DATE OF BIRTH

DATE OF DEATH

BUREAU V. S.

MAR 20 1956

RECEIVED

2414

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			
c. LENGTH OF STAY IN 1b <u>8 hrs.</u>				d. STREET ADDRESS <u>R.D. #2 Box 251</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Pelton</u> Last <u>Porter</u>			4. DATE OF DEATH Month <u>3</u> Day <u>31st</u> Year <u>19 56</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1886</u>		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mines</u>		11. BIRTHPLACE (State or foreign country) <u>Zihlman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Porter</u>				14. MOTHER'S MAIDEN NAME <u>Mahela Crowe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>212-16-8877</u>		17. INFORMANT <u>James A. Porter</u> Address <u>132 Maple Street Frostburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with gastric hemorrhage</u> DUE TO (c) <u>Ch. myocarditis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>10 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arterio-sclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>X</u> (County) (State)
21. I certify that I attended the deceased from <u>3-1</u> , 19 <u>56</u> , to <u>3-31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-30</u> , 19 <u>56</u> , and that death occurred at <u>12:30 A.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H.C. Diehl</u> M.D.				ADDRESS (Street, city or town, state) <u>Frostburg, Md.</u> DATE SIGNED <u>3/31/56</u>			
PHYSICIAN'S NAME (Type) <u>H.C. Diehl, M.D.</u>				<u>Frostburg, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-2-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Porter Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Eckhart Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Naper</u> ADDRESS <u>23 E. Main Frostburg, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 4-1-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mr. Nancy W. Lee</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the death certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2393 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jane Frazier Village Apt.15 D.</u>				d. STREET ADDRESS <u>Jane Frazier Village Apt.15 D.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Willard Lucy Rawlings</u>				4. DATE OF DEATH Month Day Year <u>March 28 19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Dec.2-1907</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife and housework for private</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>individuals</u>		11. BIRTHPLACE (State or foreign country) <u>Tunnelton, West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John T. Shrout</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Hartman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>217-10-6824</u>		17. INFORMANT Address <u>Mrs. Clarence C. Roby, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the cervix</u> DUE TO (b) <u>with metastasis.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>171X</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>March 30, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tunnelton Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Tunnelton, West Virginia.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John J. Hafer, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>March 29, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W.R. Frantz M.D.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
EDUCATION		RELIGION		MARITAL STATUS		SINGLE		MARRIED		WIDOWED		DIVORCED	
DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
EDUCATION		RELIGION		MARITAL STATUS		SINGLE		MARRIED		WIDOWED		DIVORCED	
DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	

BUREAU V. 2

APR 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2415 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02495

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural) Frostburg</u>		c. LENGTH OF STAY IN 1b <u>64 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(rural) Frostburg</u>		d. STREET ADDRESS <u>R.F.D.#3 Midlothian</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D.#3 Midlothian</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>A.</u> Last <u>Ritchie</u>				4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 7-1891</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Midlothian, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edgar Drew</u>	
14. MOTHER'S MAIDEN NAME <u>Amelia Smith</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>(husband) Anthony Ritchie, Midlothian, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary sclerosis.</u> (c) <u> </u> (c) <u> </u> </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u> </u> <u> </u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3 - 7 - 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst,</u>				ADDRESS <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>3-7-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. Stanley A. Roe</u>				24c. DATE OF SIGNATURE <u>March 5-1956</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 14 1956

RECEIVED

2394 CERTIFICATE OF DEATH

02406

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>25 yrs</u>		TOWN <u>Cumberland</u>		TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>535 Columbia Avenue</u>				STREET ADDRESS (If rural give location) <u>535 Columbia Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>SARAH</u> (Middle) <u>ALBERTA</u> (Last) <u>RUHL</u>				March 6 19 56			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 11, 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland Valley, Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMPSON F. HANKS</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>535 Columbia Avenue Wm. F. Ruhl, Cumberland, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>37 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterial Hypertension</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 6, 19 56</u> , to <u>March 6, 19 56</u> , that I last saw the deceased alive on <u>March 6, 19 56</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. W. Trevarkis, Jr.</u>		M.D. <u>Cumberland Maryland</u>		DATE SIGNED <u>3/7/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/9/56</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>March 8, 1956</u>		REGISTRAR'S SIGNATURE <u>Walter R. Lantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>		ADDRESS <u>Cumberland, Maryland</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

2004 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1. DECEASED'S NAME (Last, first, middle initial)

2. PLACE OF DEATH

3. SEX

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF CLERK

18. SIGNATURE OF ASSISTANT CLERK

19. SIGNATURE OF RECEPTIONIST

20. SIGNATURE OF TELEPHONE OPERATOR

21. SIGNATURE OF MAIL ROOM CLERK

22. SIGNATURE OF RECORDS CLERK

23. SIGNATURE OF FILE CLERK

24. SIGNATURE OF DISTRIBUTION CLERK

25. SIGNATURE OF ADDRESSING CLERK

26. SIGNATURE OF MAIL ROOM CLERK

27. SIGNATURE OF TELEPHONE OPERATOR

28. SIGNATURE OF MAIL ROOM CLERK

29. SIGNATURE OF TELEPHONE OPERATOR

30. SIGNATURE OF MAIL ROOM CLERK

31. SIGNATURE OF TELEPHONE OPERATOR

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51. SIGNATURE OF TELEPHONE OPERATOR

52. SIGNATURE OF MAIL ROOM CLERK

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57. SIGNATURE OF TELEPHONE OPERATOR

58. SIGNATURE OF MAIL ROOM CLERK

59. SIGNATURE OF TELEPHONE OPERATOR

60. SIGNATURE OF MAIL ROOM CLERK

Robert H. Heston
Robert H. Heston

BUREAU V. S.

MAR 12 1956

RECEIVED

March 21 1956
March 21 1956
March 21 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2416 CERTIFICATE OF DEATH

02407

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>VALE SUMMIT</u>		TOWN <u>VALE SUMMIT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>FROSTBURG</u>		LENGTH OF STAY (in this place) <u>1 day</u>		STREET ADDRESS		(If rural give location) <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>							
3. NAME OF DECEASED (Type or Print) <u>WILLIAM H. SCHILLER</u>				4. DATE OF DEATH (Month) <u>MARCH</u> (Day) <u>20</u> (Year) <u>1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>JANUARY 16, 1914</u>	
9. AGE last birthday <u>82</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>Johannesburg Somerset Co, PA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John C. Schiller</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET WEINOLD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>NORMAN B. SCHILLER CUMBERLAND MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
442X IMMEDIATE CAUSE (A) <u>Cerebral Accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Renal Disease</u>						years <u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 1955</u> , to <u>March 20, 1956</u> , that I last saw the deceased alive on <u>March 20, 1956</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John B. Davis</u>		M.D. <u>Frostburg, Md.</u>		DATE SIGNED <u>3/21/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>MARCH 22, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>ST. Johns Cemetery</u>		LOCATION (City, town, or county) <u>Johannesburg, Somerset Co, PA.</u> (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John Nancy N. Rie</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey N. Legler</u>		ADDRESS <u>Lyndman, Pa.</u>	
DATE <u>3-22-56</u>							

RECEIVED

2395

CERTIFICATE OF DEATH

02408

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>62 Sacred Heart Hospital</u>				d. STREET ADDRESS <u>State Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Desiree</u> Middle <u>Lynn</u> Last <u>Scott</u>				4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 23, 1955</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Robert M. Scott</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Hardley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>500X Cerebral Anoxia</u> DUE TO (b) <u>Dehydration</u> DUE TO (c) <u>Acute Bronchitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>26 hrs.</u> <u>2 d.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>May 23</u> , 19 <u>56</u> to <u>3-13</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>3-13</u> , 19 <u>56</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>51 Main Lonaconing Md</u> DATE SIGNED <u>3-14-56</u>							
ACTUAL SIGNATURE <u>George J. Richards, Jr.</u> M.D.				PHYSICIAN'S NAME (Type) <u>George J. Richards, Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/16/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	
22d. LOCATION (City, town, or county) <u>Frostburg, MD.</u>				22e. (State) <u>MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. Echhorn</u>				ADDRESS <u>Lonaconing, Md.</u>		24a. REC'D BY REGISTRAR <u>March 15, 1956 W. L. Frantz, M.D.</u>	
24b. REGISTRAR'S SIGNATURE <u>W. L. Frantz, M.D.</u>				24c. (City or town) <u>Lonaconing, Md.</u>		24d. (County) <u>Allegany</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and coroner must be filled in by the funeral director. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and coroner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2062232425

2396 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Pennsylvania</u> COUNTY <u>Bedford</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>6 Mos</u>		TOWN <u>Artemas, Pennsylvania</u>		<u>75X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>761 Fayette Street Crump Nursing Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>AMANDA</u> (Middle) <u>JANE</u> (Last) <u>SHIPLEY</u>				(Month) <u>March</u> (Day) <u>23</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>March 23, 1871</u>	<u>85</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>Pennsylvania</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>WILLIAM FLETCHER</u>				<u>NANCY WEIMER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>None</u>		<u>Walter Shipley, Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Chr. Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterial Hypertension</u>				<u>18 mos.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1, 1956</u> , to <u>Mar 23, 1956</u> , that I last saw the deceased alive on <u>Mar 20, 1956</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. W. Trivaskis, Sr.</u>		M.D. <u>Cumberland, Maryland</u>		DATE SIGNED <u>Mar 24-1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>March 26, 1956</u>		<u>Fairview Christian Cem</u>		<u>Artemas, Pennsylvania</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>March 26, 1956</u>		<u>Walter L. Frank, M.D.</u>		<u>John J. Hafer, Cumberland, Maryland</u>			

STATE OF MARYLAND DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

NAME OF DECEASED <i>John J. ...</i>		SEX M		AGE ...	
DATE OF DEATH ...		PLACE OF DEATH ...		COUNTY ...	
TIME OF DEATH ...		CAUSE OF DEATH ...		MANNER OF DEATH ...	
SIGNATURE OF PHYSICIAN <i>...</i>		SIGNATURE OF REGISTRAR <i>...</i>		SIGNATURE OF WITNESS <i>...</i>	
SIGNATURE OF DECEASED <i>...</i>		SIGNATURE OF NEXT OF KIN <i>...</i>		SIGNATURE OF ... <i>...</i>	

BUREAU V. 5

MAR 28 1951

Handwritten notes and stamps at bottom left.

Vertical text on the right margin, likely containing filing or administrative information.

2428

CERTIFICATE OF DEATH

Reg. Dist. No.

6

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barton</u>		c. LENGTH OF STAY IN 1b <u>65 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Lewis</u> First <u>Harvey</u> Middle <u>Stephen</u> Last			4. DATE OF DEATH <u>March</u> Month <u>21</u> Day Year <u>56</u> 19		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28, 1868</u>	9. AGE (In years lost day) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>			13. FATHER'S NAME <u>Peter Stephen</u>		
14. MOTHER'S MAIDEN NAME <u>Isabelle B roadwater</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>William Stephen</u> Address <u>Lonaconing, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Labor Pneumonia</u> 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>myocarditis</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>3/14</u> , 19 <u>56</u> , to <u>3/21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/21</u> , 19 <u>56</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>P.E. Berry</u>		M.D. <u>Piedmont W.Va</u>		ADDRESS (Street, city or town, state) <u>Piedmont W.Va</u>	
PHYSICIAN'S NAME (Type) <u>P.E. Berry M.D.</u>		<u>Piedmont W.Va</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried March 24, 56</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill</u>	
22d. LOCATION (City, town, or county) <u>Moscow</u>		(State) <u>Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Boral - Westernport, Md</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>3-24-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mrs. Jean C. Kelly</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 27 1956

RECEIVED

2397 CERTIFICATE OF DEATH

02411

Reg. Dist. No. 4

1. WITHIN CORPORATE LIMITS

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

YS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>11 days</u>		TOWN <u>Westernport</u>		<u>43</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Sylvan Retreat</u>				<u>146 Maryland Ave.,</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Harry</u> (Middle) <u>E</u> (Last) <u>Strieby</u>				(Month) <u>March</u> (Day) <u>14</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF OVER 24 HRS.
<u>M</u>	<u>W</u>	<u>W</u>	<u>Oct. 1, 1870</u>	<u>85</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired</u>				<u>Warrensville, Pa.</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Henry Strieby</u>				<u>Rachel Ridge</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>146, Maryland Ave.,</u> <u>Mrs. Alta Frye, Westernport, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				<u>Pulmonary Hypostasis</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Chronic Myocarditis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>Cerebral Arteriosclerosis</u>			
STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>Senile psychosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>72 hrs.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 3, 1956</u> , to <u>Mar. 14, 1956</u> , that I last saw the deceased alive on <u>Mar. 14, 1956</u> , and that death occurred at <u>7:10 p.m.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>James B. McLean M.D.</u>				<u>49 Green St.</u>		<u>3-15-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>March 18, 1956</u>		<u>Levels Cemetery</u>		<u>Levels, West Virginia.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>March 16, 1956</u>		<u>Winters R. Frantz, M.D.</u>		<u>Boal's Funeral Home, Westernport, Maryland.</u>			

11011

CERTIFICATE OF DEATH

1. Name of deceased (Print or write in full)

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Usual residence

7. Cause of death

8. Date of death

9. Time of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of witness

14. Signature of funeral director

15. Signature of undertaker

16. Signature of cemetery

17. Signature of burial place

18. Signature of interment

19. Signature of record

20. Signature of office

21. Signature of department

22. Signature of state

23. Signature of federal

24. Signature of international

25. Signature of world

26. Signature of universe

27. Signature of everything

28. Signature of all

29. Signature of nothing

30. Signature of someone

31. Signature of no one

32. Signature of everybody

33. Signature of nobody

34. Signature of almost

35. Signature of quite

36. Signature of exactly

37. Signature of approximately

38. Signature of roughly

39. Signature of more or less

40. Signature of in the neighborhood of

41. Signature of about

42. Signature of near

43. Signature of close to

44. Signature of within

45. Signature of at

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2429

CERTIFICATE OF DEATH

02412

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. D. # 6 Cumberland,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. D. # 6 Cumberland,			
c. LENGTH OF STAY IN 1b 20 yrs.				d. STREET ADDRESS Cresap Drive Bowling Green			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 70 Cresap Drive Bowling Green				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILBERT REYNOLDS THEIS				4. DATE OF DEATH Month March Day 31 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 11, 1902	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 5 Days 31 Hours 19 Min. 56		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insulation Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	
11. BIRTHPLACE (State or foreign country) Pittsburg, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Fred Theis		14. MOTHER'S MAIDEN NAME Annie Reynolds	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 217-10-4045		17. INFORMANT Mrs. Margaret E. Theis R. D. # 6 Cumberland, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Aortic Aneurism (dissecting) DUE TO (b) Arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from 3-21-56 19____, to 3-31-56 19____, that I last saw the deceased alive on 3-31-56 19____, and that death occurred at 3:19 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 3-31-56							
ACTUAL SIGNATURE C. C. Zimmerman M.D.				PHYSICIAN'S NAME (Type) C. C. ZIMMERMAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/3/56		22c. NAME OF CEMETERY OR CREMATORY Mount Lebanon Cem.		22d. LOCATION (City, town, or county) (State) Pittsburg, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Maryland				24a. REC'D BY REGISTRAR Phil 3, 1956		24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		65		M		W		JAN 15 1890		BALTIMORE		MD		MD		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		TREATMENT		HISTORY	
RETIRED		HIGH SCHOOL		MARRIED		METHODIST		HEART DISEASE		NATURAL		SEVERAL MONTHS		HOSPITAL		NONE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		CITY OF BURIAL		STATE OF BURIAL	
APR 10 1956		BALTIMORE		MD		MD		USA		APR 12 1956		BALTIMORE		MD		MD	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. 8

APR 4 1956

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02413

2430 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Route 1, Frostburg</u>		LENGTH OF STAY (In this place) <u>Lifetime</u>		TOWN <u>Route 1, Frostburg,</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				ADDRESS			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Harry</u> (Middle) <u>Tippen</u> (Last)				(Month) <u>March</u> (Day) <u>2nd</u> (Year) <u>19 56</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Male</u>		<u>White</u>		<u>Married</u>		<u>Sept. 5th, 1885</u>	
9. AGE last birthday		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>70 yrs.</u>		<u>Coal Mining</u>		<u>Maryland</u>		<u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
<u>Ret. Coal Miner</u>				<u>Coal Mining</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George Tippen</u>				<u>Margaret Morgan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>Unk.</u>				<u>201-10-8576</u>		<u>Mrs. Clara Tippen, RFD 1, Frostburg</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						<u>1 hr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Atherosclerosis, Coronary</u>						<u>YEARS</u>	
(C) <u>Silicosis, Advanced</u>						<u>YEARS</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						20. AUTOPSY?	
19a. DATE OF OPERATION						19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)						21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>						21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2</u>, 19<u>54</u>, to <u>2</u>, 19<u>56</u>, that I last saw the deceased alive on <u>2</u>, 19<u>56</u>, and that death occurred at <u>M</u>, from the causes and on the date stated above.							
SIGNATURE <u>John C. Durst</u>				DATE SIGNED <u>3/4/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				24. REC'D BY REGISTRAR			
<u>Burial</u>				<u>3-5-56</u>			
DATE THEREOF				REGISTRAR'S SIGNATURE			
<u>3 - 5 - 56</u>				<u>Mr. Nancy N. Roe</u>			
NAME OF CEMETERY OR CREMATORY				25. FUNERAL DIRECTOR'S SIGNATURE			
<u>St. Michael's Cemetery</u>				<u>Joseph R. Durst, Frostburg, Md.</u>			
LOCATION (City, town, or county)				ADDRESS			
<u>Frostburg, Md.</u>				<u>Frostburg, Md.</u>			

CERTIFICATE OF DEATH

9

Reg. Dist. No.

DECEASED PERSON'S NAME AND RESIDENCE

Age

Sex

Color

Marital Status

Occupation

Place of Birth

Usual Residence

Place of Death

Time of Death

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Mode of Death

Place of Burial

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of County Clerk

Signature of State Registrar

Signature of City Clerk

Signature of County Health Officer

Signature of City Health Officer

Signature of County Registrar

Signature of City Registrar

Signature of County Coroner

Signature of City Coroner

Signature of County Health Officer

Signature of City Health Officer

Signature of County Registrar

Signature of City Registrar

Signature of County Coroner

Signature of City Coroner

Signature of County Health Officer

Signature of City Health Officer

Signature of County Registrar

Signature of City Registrar

Signature of County Coroner

Signature of City Coroner

Signature of County Health Officer

BUREAU V. S.

MAR 8 1956

RECEIVED

DR. W.F. WILLIAMS 2398 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY Morgan			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 211 WILKES STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First IDA Middle LOWE Last TOBIAS				4. DATE OF DEATH Month MARCH Day 22 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 23, 1914	
9. AGE (In years last birthday) yrs. 41		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME STEPHEN PAGENHARDT				14. MOTHER'S MAIDEN NAME Mary McKinnon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 701		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus DUE TO (b) Cirrhosis of Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Hickman							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 11.1.1955 to 3.22.1956 , that I last saw the deceased alive on 3.21.1956 , and that death occurred at 6:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W.F. Williams				ADDRESS (Street, city or town, state) Cumberland		DATE SIGNED 3.22.56	
PHYSICIAN'S NAME (Type) W. F. Williams, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF GEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Mar 24, 1956		Philos Cemetery		Westport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer				ADDRESS Cumberland Md		24b. REC'D BY REGISTRAR March 23, 1956	
				24c. REGISTRAR'S SIGNATURE W.L. Frantz, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(11) C_{10}H_8 (1,2,3,4-tetrahydronaphthalene)

117152-1-11-12

ENTRÉE - CONTINUED

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2399 CERTIFICATE OF DEATH

02415

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY Allegany MARYLAND CITY OR TOWN Cumberland LENGTH OF STAY (in this place) 5/14/52				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Allegany CITY OR TOWN Cumberland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary				STREET ADDRESS (If rural give location) 735 Fayette Street			
3. NAME OF DECEASED (Type or Print) (First) Anna (Middle) Uhl (Last)				4. DATE OF DEATH (Month) (Day) (Year) March 15, 1956			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 12/14/1870	9. AGE last birthday 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Frankfort, Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Christian Weisenmiller				14. MOTHER'S MAIDEN NAME Marie Missie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Allegany County Infirmary Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Chronic myocarditis						INTERVAL BETWEEN ONSET AND DEATH ?	
ANTECEDENT CAUSE(S) DUE TO (B) Diffuse arteriosclerosis						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Hypertension						?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile psychosis						3 yrs. -	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1952 19....., to Mar 15, 1956 , that I last saw the deceased alive on Mar 14, 1956 , and that death occurred at 5:30 AM , from the causes and on the date stated above.							
SIGNATURE James E. T. Chan M.D.				ADDRESS (Street, city, town, state) 49 Greene St.		DATE SIGNED 3-15-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3/17/56		NAME OF CEMETERY OR CREMATORY St. Peter & Paul		LOCATION (City, town, or county) (State) Cumberland Maryland	
24. REC'D BY REGISTRAR March 17, 1956		REGISTRAR'S SIGNATURE Walter K. Leary, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc.		ADDRESS Cumberland, Md.	

3399 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

3399

DATE OF DEATH

AT USUAL RESIDENCE OTHER THAN DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE OF DECEASED

SEX OF DECEASED

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

AGE OF DECEASED

SEX OF DECEASED

DATE OF DEATH

TIME OF DEATH

AGE OF DECEASED

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BUREAU V. S.

MAR 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2400 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02416

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		c. LENGTH OF STAY IN 1b <u>73 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> <u>02</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dead on arrival at Sacred H. Hospital</u>				d. STREET ADDRESS <u>473 Baltimore Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dennis</u> Middle <u>Fredrick</u> Last <u>Wagner</u>				4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17-1882</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u>	IF UNDER 24 HRS. Hours <u>73</u> Min. <u>73</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam Crane operator, B&O.R.Ry.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Green Spring, W.Va.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Wagner</u>				14. MOTHER'S MAIDEN NAME <u>Martha Jane Kerns</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-12-3266</u>		17. INFORMANT (Address) <u>daughter) Mrs. R. Dern, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 19-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 21, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>March 20, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Brantzy, M.D.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BAYSHORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
HISTORY OF PRESENT ILLNESS		PREVIOUS ILLNESSES		TREATMENT		HISTORY OF ALCOHOLIC DRINKING		HISTORY OF TOBACCO SMOKING		HISTORY OF DRUG USE	
FINDINGS AT AUTOPSY		LABORATORY EXAMINATIONS		TOXICOLOGY		HISTOPATHOLOGY		MICROBIOLOGY		OTHER	
SIGNATURE OF EXAMINER		DATE		PLACE		TITLE		HOSPITAL		CITY	

BUREAU V. S.

MAR 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2431

CERTIFICATE OF DEATH

02417

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Church Street				d. STREET ADDRESS Church Street			
3. NAME OF DECEASED (Type or print) First GEORGE Middle WALLACE Last WALLACE				4. DATE OF DEATH Month 3 Day 16 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 22, 1887	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 6 Days 16 Hours 19 Min. 56		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	
11. BIRTHPLACE (State or foreign country) Scotland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Wallace				14. MOTHER'S MAIDEN NAME Christina Main			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Edward Hunter, Lonaconing, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 322.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential Hypertension (c) Alcoholism						INTERVAL BETWEEN ONSET AND DEATH Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (SISTER)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Lonaconing, Md.				20g. (County) (State)			
21. I certify that I attended the deceased from Nov. 28, 1955 to Mar. 1956 , that I last saw the deceased alive on March 15, 1956 , and that death occurred at 1 a. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lonaconing, Md. DATE SIGNED Leslie R. Miles, Jr., M.D.							
ACTUAL SIGNATURE Leslie R. Miles, Jr. M.D.							
PHYSICIAN'S NAME (Type) Leslie R. Miles, Jr., M.D. Lonaconing, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/56		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN, Lonaconing, MD.				24a. REC'D BY REGISTRAR 3-18-56		24b. REGISTRAR'S SIGNATURE Jannet M. Boal	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		SEX MALE		DATE OF BIRTH JAN 5, 1928		PLACE OF BIRTH MOBILE, ALABAMA	
MARRIAGE SINGLE		OCCUPATION MEMBER OF CONGRESS		PRESENT ADDRESS 435 N. LAUREL AVE., BALTIMORE, MD.		DATE OF DEATH APR 4, 1968	
PLACE OF DEATH BALTIMORE, MD.		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		TIME OF DEATH 11:57 AM	
SIGNATURE OF PHYSICIAN J. H. HARRIS		SIGNATURE OF CORONER J. H. HARRIS		SIGNATURE OF REGISTRAR J. H. HARRIS		SIGNATURE OF WITNESS J. H. HARRIS	
NAME OF FUNERAL HOME J. H. HARRIS		NAME OF BURIAL PLACE J. H. HARRIS		NAME OF CEMETERY J. H. HARRIS		NAME OF MINISTER J. H. HARRIS	

BUREAU V. 3

MAR 22 1968

RECEIVED

1
Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02418

2401 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>				TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>313 Central Avenue</u>				STREET ADDRESS (If rural give location) <u>313 Central Avenue</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>EULA BELLE WELLS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 22 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 27, 1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARCELLUS EDWARDS</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE FRANCIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Reginald Wells, 313 Central Avenue, Cumberland, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
174X IMMEDIATE CAUSE (A) <u>Carcinoma Uterus</u>						<u>6 months</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1956</u> , to <u>3/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/22</u> , 19 <u>56</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George M. Simon</u>				ADDRESS (Street, city, town, state) <u>Cumberland, Md</u>		DATE SIGNED <u>3/22/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/24/56</u>		NAME OF CEMETERY OR CREMATORY <u>Sumner Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>March 24, 1956</u>		REGISTRAR'S SIGNATURE <u>W.D. Lantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Form 100-1

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF CLERK

21. SIGNATURE OF ASSISTANT CLERK

22. SIGNATURE OF RECEPTIONIST

23. SIGNATURE OF TELEPHONE OPERATOR

24. SIGNATURE OF MAIL ROOM

25. SIGNATURE OF RECORDS SECTION

26. SIGNATURE OF STATISTICS SECTION

27. SIGNATURE OF LABORATORY

28. SIGNATURE OF RADIOLOGY

29. SIGNATURE OF PATHOLOGY

30. SIGNATURE OF ANATOMY

31. SIGNATURE OF PHYSIOLOGY

32. SIGNATURE OF PSYCHOLOGY

33. SIGNATURE OF SOCIOLOGY

34. SIGNATURE OF POLITICAL SCIENCE

35. SIGNATURE OF ECONOMICS

36. SIGNATURE OF HISTORY

37. SIGNATURE OF GEOGRAPHY

38. SIGNATURE OF ASTRONOMY

39. SIGNATURE OF PHYSICS

40. SIGNATURE OF CHEMISTRY

41. SIGNATURE OF BIOLOGY

42. SIGNATURE OF MEDICINE

43. SIGNATURE OF DENTISTRY

44. SIGNATURE OF VETERINARY MEDICINE

45. SIGNATURE OF PHARMACY

46. SIGNATURE OF NURSING

47. SIGNATURE OF OPTOMETRY

48. SIGNATURE OF PODIATRY

49. SIGNATURE OF CHIROPY

50. SIGNATURE OF MASSAGE

51. SIGNATURE OF YOGA

52. SIGNATURE OF MEDITATION

53. SIGNATURE OF TAI CHI

54. SIGNATURE OF QIGONG

55. SIGNATURE OF JIU JITSU

56. SIGNATURE OF KARATE

57. SIGNATURE OF JUDO

58. SIGNATURE OF KUNG FU

59. SIGNATURE OF SAMBO

60. SIGNATURE OF HAKKAIDO

61. SIGNATURE OF JIU JITSU

62. SIGNATURE OF KARATE

63. SIGNATURE OF JUDO

64. SIGNATURE OF KUNG FU

65. SIGNATURE OF SAMBO

66. SIGNATURE OF HAKKAIDO

67. SIGNATURE OF JIU JITSU

68. SIGNATURE OF KARATE

69. SIGNATURE OF JUDO

70. SIGNATURE OF KUNG FU

71. SIGNATURE OF SAMBO

72. SIGNATURE OF HAKKAIDO

73. SIGNATURE OF JIU JITSU

74. SIGNATURE OF KARATE

75. SIGNATURE OF JUDO

76. SIGNATURE OF KUNG FU

77. SIGNATURE OF SAMBO

78. SIGNATURE OF HAKKAIDO

79. SIGNATURE OF JIU JITSU

80. SIGNATURE OF KARATE

81. SIGNATURE OF JUDO

82. SIGNATURE OF KUNG FU

83. SIGNATURE OF SAMBO

84. SIGNATURE OF HAKKAIDO

85. SIGNATURE OF JIU JITSU

86. SIGNATURE OF KARATE

87. SIGNATURE OF JUDO

88. SIGNATURE OF KUNG FU

89. SIGNATURE OF SAMBO

90. SIGNATURE OF HAKKAIDO

91. SIGNATURE OF JIU JITSU

92. SIGNATURE OF KARATE

93. SIGNATURE OF JUDO

94. SIGNATURE OF KUNG FU

95. SIGNATURE OF SAMBO

96. SIGNATURE OF HAKKAIDO

97. SIGNATURE OF JIU JITSU

98. SIGNATURE OF KARATE

99. SIGNATURE OF JUDO

100. SIGNATURE OF KUNG FU

101. SIGNATURE OF SAMBO

102. SIGNATURE OF HAKKAIDO

103. SIGNATURE OF JIU JITSU

104. SIGNATURE OF KARATE

105. SIGNATURE OF JUDO

106. SIGNATURE OF KUNG FU

107. SIGNATURE OF SAMBO

108. SIGNATURE OF HAKKAIDO

109. SIGNATURE OF JIU JITSU

110. SIGNATURE OF KARATE

111. SIGNATURE OF JUDO

112. SIGNATURE OF KUNG FU

113. SIGNATURE OF SAMBO

114. SIGNATURE OF HAKKAIDO

115. SIGNATURE OF JIU JITSU

116. SIGNATURE OF KARATE

117. SIGNATURE OF JUDO

118. SIGNATURE OF KUNG FU

119. SIGNATURE OF SAMBO

120. SIGNATURE OF HAKKAIDO

121. SIGNATURE OF JIU JITSU

122. SIGNATURE OF KARATE

123. SIGNATURE OF JUDO

124. SIGNATURE OF KUNG FU

125. SIGNATURE OF SAMBO

126. SIGNATURE OF HAKKAIDO

127. SIGNATURE OF JIU JITSU

128. SIGNATURE OF KARATE

129. SIGNATURE OF JUDO

130. SIGNATURE OF KUNG FU

131. SIGNATURE OF SAMBO

132. SIGNATURE OF HAKKAIDO

133. SIGNATURE OF JIU JITSU

134. SIGNATURE OF KARATE

135. SIGNATURE OF JUDO

136. SIGNATURE OF KUNG FU

137. SIGNATURE OF SAMBO

138. SIGNATURE OF HAKKAIDO

139. SIGNATURE OF JIU JITSU

140. SIGNATURE OF KARATE

141. SIGNATURE OF JUDO

142. SIGNATURE OF KUNG FU

143. SIGNATURE OF SAMBO

144. SIGNATURE OF HAKKAIDO

145. SIGNATURE OF JIU JITSU

146. SIGNATURE OF KARATE

147. SIGNATURE OF JUDO

148. SIGNATURE OF KUNG FU

149. SIGNATURE OF SAMBO

150. SIGNATURE OF HAKKAIDO

151. SIGNATURE OF JIU JITSU

152. SIGNATURE OF KARATE

153. SIGNATURE OF JUDO

154. SIGNATURE OF KUNG FU

155. SIGNATURE OF SAMBO

156. SIGNATURE OF HAKKAIDO

157. SIGNATURE OF JIU JITSU

158. SIGNATURE OF KARATE

159. SIGNATURE OF JUDO

160. SIGNATURE OF KUNG FU

161. SIGNATURE OF SAMBO

162. SIGNATURE OF HAKKAIDO

163. SIGNATURE OF JIU JITSU

164. SIGNATURE OF KARATE

165. SIGNATURE OF JUDO

166. SIGNATURE OF KUNG FU

167. SIGNATURE OF SAMBO

168. SIGNATURE OF HAKKAIDO

169. SIGNATURE OF JIU JITSU

170. SIGNATURE OF KARATE

171. SIGNATURE OF JUDO

172. SIGNATURE OF KUNG FU

173. SIGNATURE OF SAMBO

174. SIGNATURE OF HAKKAIDO

175. SIGNATURE OF JIU JITSU

176. SIGNATURE OF KARATE

177. SIGNATURE OF JUDO

178. SIGNATURE OF KUNG FU

179. SIGNATURE OF SAMBO

180. SIGNATURE OF HAKKAIDO

181. SIGNATURE OF JIU JITSU

182. SIGNATURE OF KARATE

183. SIGNATURE OF JUDO

184. SIGNATURE OF KUNG FU

185. SIGNATURE OF SAMBO

186. SIGNATURE OF HAKKAIDO

187. SIGNATURE OF JIU JITSU

188. SIGNATURE OF KARATE

189. SIGNATURE OF JUDO

190. SIGNATURE OF KUNG FU

191. SIGNATURE OF SAMBO

192. SIGNATURE OF HAKKAIDO

193. SIGNATURE OF JIU JITSU

194. SIGNATURE OF KARATE

195. SIGNATURE OF JUDO

196. SIGNATURE OF KUNG FU

197. SIGNATURE OF SAMBO

198. SIGNATURE OF HAKKAIDO

199. SIGNATURE OF JIU JITSU

200. SIGNATURE OF KARATE

201. SIGNATURE OF JUDO

202. SIGNATURE OF KUNG FU

203. SIGNATURE OF SAMBO

204. SIGNATURE OF HAKKAIDO

205. SIGNATURE OF JIU JITSU

206. SIGNATURE OF KARATE

207. SIGNATURE OF JUDO

208. SIGNATURE OF KUNG FU

209. SIGNATURE OF SAMBO

210. SIGNATURE OF HAKKAIDO

211. SIGNATURE OF JIU JITSU

212. SIGNATURE OF KARATE

213. SIGNATURE OF JUDO

214. SIGNATURE OF KUNG FU

215. SIGNATURE OF SAMBO

216. SIGNATURE OF HAKKAIDO

217. SIGNATURE OF JIU JITSU

218. SIGNATURE OF KARATE

219. SIGNATURE OF JUDO

220. SIGNATURE OF KUNG FU

221. SIGNATURE OF SAMBO

222. SIGNATURE OF HAKKAIDO

223. SIGNATURE OF JIU JITSU

224. SIGNATURE OF KARATE

225. SIGNATURE OF JUDO

226. SIGNATURE OF KUNG FU

227. SIGNATURE OF SAMBO

228. SIGNATURE OF HAKKAIDO

229. SIGNATURE OF JIU JITSU

230. SIGNATURE OF KARATE

231. SIGNATURE OF JUDO

232. SIGNATURE OF KUNG FU

233. SIGNATURE OF SAMBO

234. SIGNATURE OF HAKKAIDO

235. SIGNATURE OF JIU JITSU

236. SIGNATURE OF KARATE

237. SIGNATURE OF JUDO

238. SIGNATURE OF KUNG FU

239. SIGNATURE OF SAMBO

240. SIGNATURE OF HAKKAIDO

241. SIGNATURE OF JIU JITSU

242. SIGNATURE OF KARATE

243. SIGNATURE OF JUDO

244. SIGNATURE OF KUNG FU

245. SIGNATURE OF SAMBO

246. SIGNATURE OF HAKKAIDO

247. SIGNATURE OF JIU JITSU

248. SIGNATURE OF KARATE

249. SIGNATURE OF JUDO

250. SIGNATURE OF KUNG FU

251. SIGNATURE OF SAMBO

252. SIGNATURE OF HAKKAIDO

253. SIGNATURE OF JIU JITSU

254. SIGNATURE OF KARATE

255. SIGNATURE

2402

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL
and give nearest town)TOWN CumberlandLENGTH OF STAY
(in this place)
47yrsHOSPITAL OR
INSTITUTION OR
STREET ADDRESS23 W. Robert St.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MarylandCOUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Cumberland, Md.STREET
ADDRESS(If rural give location)
23 W. Robert St.3. NAME OF
DECEASED
(Type or Print)

(First)

Elizabeth

(Middle)

Whitacre

(Last)

4. DATE
OF
DEATH

(Month)

(Day)

(Year)

3-II-56

19

5. SEX

F6. COLOR OR
RACEW7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)Widowed

8. DATE OF BIRTH

Dec. 26, 1871

9. AGE last birthday

84

yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)Housewife10b. KIND OF BUSINESS
OR INDUSTRYOwn Home

11. BIRTHPLACE (State or foreign country)

Dryridge, Bedford Co. Pa.12. CITIZEN OF WHAT
COUNTRY?USA

13. FATHER'S NAME

Alexander Holler

14. MOTHER'S MAIDEN NAME

Mary Gondon15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)No

16. SOCIAL SECURITY NO.

None

17. INFORMANT & ADDRESS

23 W. Robert StMrs. Anna Shanholtz Cumberland, Md

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

592X IMMEDIATE CAUSE

(A)

Chronic Nephritis & Uremia -

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(B)

Diabetes & Age

(C)

11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN
ONSET AND DEATH3 mo21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While ☐ Not while ☐
et work et work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/14/55, 19....., to 3/13/56, 19....., that I last saw the deceased
alive on 3/13/56, 19....., and that death occurred at 4:45p M., from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial3-16-56Hyndman Cem.Hyndman, Pa.

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

March 15, 1956 Walter R. Frantz, M.D.James F. Scarnelli, Cumberland, Md

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2403 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02420**

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		c. LENGTH OF STAY IN lb 35 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 02 Sacred Heart Hospital		d. STREET ADDRESS 110 W. 3rd. St.	
3. NAME OF DECEASED (Type or print) Susanne Wickard		4. DATE OF DEATH March 28 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29-1874
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James McKenzie		14. MOTHER'S MAIDEN NAME Sarah McKenzie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Frances Wickard, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) ? DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH about 8 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 28-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 31, 1956	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Maryland.		ADDRESS	
24a. REC'D BY REGISTRAR Apr. 4, 1956		24b. REGISTRAR'S SIGNATURE Walter K. Frantz	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		SIGNATURE OF WITNESS		DATE		PLACE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF EXAMINER		SIGNATURE OF WITNESS		SIGNATURE OF EXAMINER		SIGNATURE OF WITNESS		SIGNATURE OF EXAMINER		SIGNATURE OF WITNESS		SIGNATURE OF EXAMINER	

RECEIVED
 APR 4 1955
 BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02421

2417 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		TOWN <u>Frostburg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		LENGTH OF STAY (In this place) <u>10 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		TOWN <u>Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>		STREET ADDRESS (If rural give location) <u>134 Bowery St.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		TOWN <u>Frostburg</u>	
3. NAME OF DECEASED (Type or Print) <u>EMMA W. WILLIAMS</u>				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>29</u> (Year) <u>1956</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>5-5-1897</u>	
9. AGE last birthday <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Whetstone</u>				14. MOTHER'S MAIDEN NAME <u>Katherine House</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>none</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT & ADDRESS <u>Cambira Williams, Frostburg, Md.</u>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
331X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>				11 days			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Malignant hypertension</u>				2 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Modest arterio-sclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
20c. WHERE DID INJURY OCCUR? (City or town) (County) (State)				20d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>3-18</u> , 19 <u>56</u> , to <u>3-29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-29</u> , 19 <u>56</u> , and that death occurred at <u>5 P.</u> M. from the causes and on the date stated above.			
20e. INJURY OCCURRED White <input checked="" type="checkbox"/> Not white <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>				20f. HOW DID INJURY OCCUR?			
21. I hereby certify that I attended the deceased from <u>3-18</u> , 19 <u>56</u> , to <u>3-29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-29</u> , 19 <u>56</u> , and that death occurred at <u>5 P.</u> M. from the causes and on the date stated above.				22. I hereby certify that I attended the deceased from <u>3-18</u> , 19 <u>56</u> , to <u>3-29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-29</u> , 19 <u>56</u> , and that death occurred at <u>5 P.</u> M. from the causes and on the date stated above.			
SIGNATURE <u>H. C. Diehl</u>				ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u> DATE SIGNED <u>3/30/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>4-1-1956</u>			
NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>				LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>			
24. REC'D BY REGISTRAR <u>Wm. Nancy N. Rose</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst</u> ADDRESS <u>Frostburg, Md.</u>			
DATE <u>4-1-56</u>							

CERTIFICATE OF DEATH

FILE NO.

PLACE OF DEATH (If not at home, give name of institution)

NAME OF DECEASED (Print name in full)

SEX

AGE

DATE OF BIRTH

DATE OF DEATH

TIME

PLACE OF DEATH

CAUSE OF DEATH (Give full description)

DATE OF DEATH

TIME

PLACE OF DEATH

DATE OF DEATH

TIME

PLACE OF DEATH

DATE OF DEATH

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PLACE OF DEATH

BUREAU OF VITALS

APR 4 1956

RECEIVED

2418

CERTIFICATE OF DEATH

02422

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 61 MINERS HOSPITAL		d. STREET ADDRESS Lyric Apts., E. Main St.	
3. NAME OF DECEASED (Type or print) CHESTER HARRISON WILSON		4. DATE OF DEATH Month 3 Day 1st Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-28-1892
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kelly Worker		10b. KIND OF BUSINESS OR INDUSTRY Kelly Springfield Shaft, Ind.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore Wilson		14. MOTHER'S MAIDEN NAME Rebecca Shell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 214-07-0045	
17. INFORMANT Mrs. Glenn Jenkins, Tacoma Park, Wash.		18. ADDRESS 8625 Flower Avenue, DC.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial damage from DUE TO (c) Previous attack Apr 1955 10 mos		INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 55 , to 3-1 , 19 56 , that I last saw the deceased alive on 3-1 , 19 56 , and that death occurred at 8 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H.C. Diehl		DATE SIGNED 3/2/56	
PHYSICIAN'S NAME (Type) H.C. Diehl, M.D.		ADDRESS (Street, city or town, state) Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-4-56	22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery	22d. LOCATION (City, town, or county) (State) Frostburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE B. H. Montesant		24a. REC'D BY REGISTRAR 23 E. Main, Frostburg	
24b. REGISTRAR'S SIGNATURE Mrs. Nancy A. Rae		DATE 3-4-56	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the death certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5118

1. NAME OF DECEASED <i>Robert M. Jones</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1911</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Engineer</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>June 10 1935</i>	
9. PLACE OF DEATH <i>Home</i>		10. CAUSE OF DEATH <i>Myocardial Infarction</i>	
11. MEDICAL HISTORY <i>None</i>		12. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
13. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		14. SIGNATURE OF WITNESS <i>John D. Doe</i>	
15. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		16. SIGNATURE OF WITNESS <i>John D. Doe</i>	
17. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		18. SIGNATURE OF WITNESS <i>John D. Doe</i>	
19. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		20. SIGNATURE OF WITNESS <i>John D. Doe</i>	
21. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		22. SIGNATURE OF WITNESS <i>John D. Doe</i>	
23. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		24. SIGNATURE OF WITNESS <i>John D. Doe</i>	
25. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		26. SIGNATURE OF WITNESS <i>John D. Doe</i>	
27. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		28. SIGNATURE OF WITNESS <i>John D. Doe</i>	
29. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		30. SIGNATURE OF WITNESS <i>John D. Doe</i>	
31. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		32. SIGNATURE OF WITNESS <i>John D. Doe</i>	
33. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		34. SIGNATURE OF WITNESS <i>John D. Doe</i>	
35. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		36. SIGNATURE OF WITNESS <i>John D. Doe</i>	
37. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		38. SIGNATURE OF WITNESS <i>John D. Doe</i>	
39. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		40. SIGNATURE OF WITNESS <i>John D. Doe</i>	
41. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		42. SIGNATURE OF WITNESS <i>John D. Doe</i>	
43. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		44. SIGNATURE OF WITNESS <i>John D. Doe</i>	
45. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		46. SIGNATURE OF WITNESS <i>John D. Doe</i>	
47. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		48. SIGNATURE OF WITNESS <i>John D. Doe</i>	
49. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		50. SIGNATURE OF WITNESS <i>John D. Doe</i>	
51. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		52. SIGNATURE OF WITNESS <i>John D. Doe</i>	
53. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		54. SIGNATURE OF WITNESS <i>John D. Doe</i>	
55. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		56. SIGNATURE OF WITNESS <i>John D. Doe</i>	
57. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		58. SIGNATURE OF WITNESS <i>John D. Doe</i>	
59. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		60. SIGNATURE OF WITNESS <i>John D. Doe</i>	
61. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		62. SIGNATURE OF WITNESS <i>John D. Doe</i>	
63. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		64. SIGNATURE OF WITNESS <i>John D. Doe</i>	
65. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		66. SIGNATURE OF WITNESS <i>John D. Doe</i>	
67. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		68. SIGNATURE OF WITNESS <i>John D. Doe</i>	
69. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		70. SIGNATURE OF WITNESS <i>John D. Doe</i>	
71. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		72. SIGNATURE OF WITNESS <i>John D. Doe</i>	
73. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		74. SIGNATURE OF WITNESS <i>John D. Doe</i>	
75. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		76. SIGNATURE OF WITNESS <i>John D. Doe</i>	
77. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		78. SIGNATURE OF WITNESS <i>John D. Doe</i>	
79. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		80. SIGNATURE OF WITNESS <i>John D. Doe</i>	
81. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		82. SIGNATURE OF WITNESS <i>John D. Doe</i>	
83. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		84. SIGNATURE OF WITNESS <i>John D. Doe</i>	
85. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		86. SIGNATURE OF WITNESS <i>John D. Doe</i>	
87. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		88. SIGNATURE OF WITNESS <i>John D. Doe</i>	
89. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		90. SIGNATURE OF WITNESS <i>John D. Doe</i>	
91. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		92. SIGNATURE OF WITNESS <i>John D. Doe</i>	
93. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		94. SIGNATURE OF WITNESS <i>John D. Doe</i>	
95. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		96. SIGNATURE OF WITNESS <i>John D. Doe</i>	
97. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		98. SIGNATURE OF WITNESS <i>John D. Doe</i>	
99. SIGNATURE OF DECEASED <i>Robert M. Jones</i>		100. SIGNATURE OF WITNESS <i>John D. Doe</i>	

BUREAU V. S.

MAR 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2404

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02423

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>134 Bedford St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Heleh Wineow</u>				4. DATE OF DEATH Month Day Year <u>March 25 19 56</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16-1894</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Stanley</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Webster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>(niece) Mrs. Harold B. Smith, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic carcinoma of the uterus.</u> DUE TO (c) <u>?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>March 26-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 28, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>March 27, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Frantz, M.D.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH	
6. PLACE OF DEATH		7. CITY		8. COUNTY		9. STATE		10. ZIP CODE	
11. OCCUPATION		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. MEDICAL HISTORY		15. PRESENT ILLNESS	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF WITNESS		18. SIGNATURE OF DECEASED		19. SIGNATURE OF NEXT OF KIN		20. SIGNATURE OF CLERK	

BUREAU V. 31

MAR 28 1956

RECEIVED

2405

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland				c. LENGTH OF STAY IN lb 5 Mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 210 Paca St.,				d. STREET ADDRESS 210 Paca St.,			
3. NAME OF DECEASED (Type or print) First CAROL Middle ANN Last WITT				4. DATE OF DEATH Month March Day 14, Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1955		9. AGE (In years lost birthday) yrs. 5	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 14 Days 14 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James W. Witt				14. MOTHER'S MAIDEN NAME JoAnn Willison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. James W. Witt 210 Paca St., Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 085.1 Virus Pneumonia - (bvt) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) measles DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Open Roman Ovale						INTERVAL BETWEEN ONSET AND DEATH 3 day 3 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-9-56 to 3-15-56 , that I last saw the deceased alive on 3-12-56 , and that death occurred at 12 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. W. Eliason M.D.				ADDRESS (Street, City or town, State) 126 Union St., Cumberland, Maryland DATE SIGNED 3/15/56			
PHYSICIAN'S NAME (Type) Dr. H. W. Eliason		126 Union St., Cumberland, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16/56		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Maryland			
24a. REC'D BY REGISTRAR March 15, 1956				24b. REGISTRAR'S SIGNATURE W. R. Harty, M.D.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2406

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02425

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		c. LENGTH OF STAY IN 1b <u>15 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> <u>02</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>00 247 Columbia St.</u>				d. STREET ADDRESS <u>247 Columbia St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Watkins</u> Last <u>Woltz</u>				4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29-1882</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>73</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired nightwatchman-Liberty Trust</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hagerstown, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eli Woltz</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Albert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-05-6097</u>		17. INFORMANT <u>(son) William Woltz, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO (b) <u>Myocarditis with hypertention</u> (c) <u>Arteriosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>Gradual</u> <u>about 2 years.</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> <u>H. V. Deming</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>March 5-1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 7, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sts. Peter & Paul Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>March 6, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Frantz, M.D.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15
 3500 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH	
6. PLACE OF DEATH		7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF EXAMINER	
11. SIGNATURE OF WITNESS		12. SIGNATURE OF WITNESS		13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS		19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS	
21. SIGNATURE OF WITNESS		22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS		25. SIGNATURE OF WITNESS	
26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS	
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51. SIGNATURE OF WITNESS		52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS		55. SIGNATURE OF WITNESS	
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71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS		73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS		79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS	
81. SIGNATURE OF WITNESS		82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS		85. SIGNATURE OF WITNESS	
86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS		88. SIGNATURE OF WITNESS		89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS		94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS	
96. SIGNATURE OF WITNESS		97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS		100. SIGNATURE OF WITNESS	

RECEIVED
 MAR 8 1956
 BUREAU V. S.